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Departmental Performance Report

Health Canada • 2007 - 2008

For the period ending March 31, 2008

Canada

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Section I

Overview

Minister's Message

As Canada's new Minister of Health, I am pleased to present Health Canada's 2007–2008 *Departmental Performance Report* (DPR), which outlines the Department's and the Government's health-related accomplishments as well as progress in fulfilling its commitments to Canadians during the past year.

As a former Minister of Health and Social Services for Nunavut, the portfolio is one that is of great interest to me. I plan to continue the important work begun by my predecessor, the Honourable Tony Clement, and will be addressing new priorities as the needs of Canadians evolve.

The *Departmental Performance Report* shows that this department has followed the agenda outlined in the 2007 Speech from the Throne; the 2007 and 2008 Budgets, Health Canada's 2007–2008 *Report on Plans and Priorities*; and in government-wide initiatives. We have taken on those commitments and responded with important innovations that are addressing the health priorities of Canadians.

The Food and Consumer Safety Action Plan, announced by the Prime Minister in December 2007, draws on lessons learned by Health Canada as it works to reduce risks associated with the safety of food as well as health and consumer products. The Department played a central role in supporting the Government by working toward modernizing Canada's regulatory system for health and consumer products and food. Health Canada has taken an active role in encouraging industry to bring innovative, safe and effective health products to the market.

For all Canadians, health is affected by the air that we breathe and the space we inhabit. Environment Canada and Health Canada are partners with respect to the government's Clean Air Agenda and Chemicals Management Plan, which builds on Canada's position as a global leader in the safe management of chemical substances and products. We are beginning to implement an Air Quality Health Index and are assessing the health risks from indoor and outdoor sources of air pollution. Health Canada is also monitoring more than 200 chemicals that may be hazardous to the health of Canadians. This monitoring may lead to future regulations of some of those chemicals.

Health Canada continues to work towards coordinated and innovative approaches to improve the overall health outcomes and ensure access to health services for First Nations and Inuit communities. In 2007, the Governments of Canada and British Columbia and the First Nations Leadership Council signed Canada's first Tripartite First Nations Health Plan. This plan commits these parties to work together to create a new governance structure that will enhance First Nations involvement in the delivery of health services and promote better integration and coordination of federally and provincially funded health services.

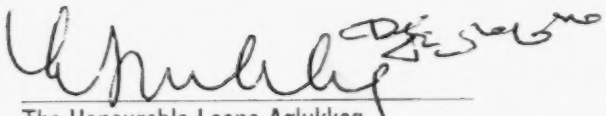
The National Anti-Drug Strategy, announced in 2007, is a collaborative effort involving the Department of Justice, Health Canada, and Public Safety Canada. This Strategy has three components: preventing illicit drug use; treating those with illicit drug dependencies; and combating production and distribution of illicit drugs. On behalf of all partners, Health Canada led development of the prevention and treatment components of the Strategy.

Of course, health encompasses more than physical well-being; it includes mental well-being. In 2007, the Government created the Mental Health Commission of Canada to develop a national approach to improving the quality of life for Canadians and their families living with mental illness. Along with the initial investment of $130 million over 10 years, the Government, through Budget 2008, committed an additional $110 million over five years to fund national research projects related to mental health and homelessness.

Health Canada continues to demonstrate leadership in helping provincial and territorial governments establish wait time guarantees. Through our programs, access to priority treatments such as cancer radiation, cataract surgery, hip and knee replacement, cardiac care, diagnostic care and primary health care will be accelerated in treatment centres across the country.

As part of a government-wide effort, led by the Public Health Agency of Canada and the Canadian Food Inspection Agency, Health Canada continues to actively participate, both domestically and internationally, in working to ensure that Canada is well prepared to deal with both avian and pandemic influenza.

As Minister of Health, I am proud of Health Canada's accomplishments in 2007-2008. Through the achievements mentioned here and through our ongoing programs, services and initiatives, we continue to help Canadians maintain and improve their health, while respecting individual choices and circumstances.



The Honourable Leona Aglukkaq
Minister of Health
Government of Canada

Management Representation Statement

I submit for tabling in Parliament, the 2007-2008 *Departmental Performance Report* for Health Canada.

This document has been prepared based on the reporting principles contained in the *Guide for the Preparation of Part III of the 2007-2008 Estimates: Reports on Plans and Priorities and Departmental Performance Reports:*

- It adheres to the specific reporting requirements outlined in the Treasury Board Secretariat guidance;
- It is based on the Department's Strategic Outcomes and Program Activity Architecture that were approved by the Treasury Board;
- It presents consistent, comprehensive, balanced and reliable information;
- It provides a basis of accountability for the results achieved with the resources and authorities entrusted to it; and
- It reports finances based on approved numbers from the Estimates and the Public Accounts of Canada.

Morris Rosenberg
Deputy Minister

Summary Information

About Health Canada

Health Canada was established to help the people of Canada maintain and improve their health. We are also committed to improving the lives of all Canadians and making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

Health Canada develops, implements and enforces regulations, legislation, policies, programs, services and initiatives and works with other federal partners, the provinces and territories to maintain and improve the overall health of Canadians. As administrator of the *Canada Health Act*, we ensure that the principles of Canada's universal health care are respected, allowing Canadians to be confident in the services they receive from the public health care system. The Minister of Health is also responsible for direct administration of another 18 statutes including the *Food and Drugs Act*, the *Pest Control Products Act* and the *Controlled Drugs and Substances Act*.[1]

We provide policy leadership and portfolio coordination among our partners in the Government of Canada's **Health Portfolio**, each of which produces its own *Departmental Performance Report*:

- Assisted Human Reproduction Canada;
- Canadian Institutes of Health Research;
- Hazardous Materials Information Review Commission;
- Patented Medicine Prices Review Board;
- Public Health Agency of Canada.

Our Objectives

By working with others in a manner that fosters the trust of Canadians, Health Canada strives to:

- prevent and reduce risks to individual health and the overall environment and enhance the sustainability, innovation and integration of the health system;
- promote healthier lifestyles through sustained health protection and regulations;
- ensure high quality health services that are efficient and accessible;
- integrate renewal of the health care system with longer term plans in areas of prevention, health promotion and protection;
- reduce health inequalities in Canadian society; and
- provide health information to help Canadians make informed decisions.

[1] For more information on legislative acts, please visit the Department of Justice website at: http://laws.justice.gc.ca/en

Our Roles

Health Canada employees play key roles in promoting, protecting and improving the health of Canadians - roles that assist other stakeholders working towards the same goals. Our Department has roles that include conducting leading-edge science, developing policies and managing and delivering programs and services across Canada as indicated on the accompanying map. We have broad regulatory responsibilities for oversight of health products, food, consumer products and pesticides, as well as responsibility for monitoring the *Canada Health Act*. This Department develops and shares knowledge to educate Canadians about health topics and issues, enabling citizens to understand our health system and gain awareness of ways to improve their own health and that of their families and communities. Health Canada works with health system stakeholders and individual Canadians to build cooperative links to address issues of common concern. In all these efforts, we are committed to transparent decision-making.

Health Canada at Work across the Country

Reporting Structure

Consistent with the direction of the Treasury Board of Canada, this *Departmental Performance Report* and accompanying financial tables are presented using the Health Canada Program Activity Architecture (PAA) in place in 2007-2008. The PAA provides a framework for departments and agencies to organize program activities and present information on accomplishments against its plans and priorities. The Health Canada PAA has four Strategic Outcomes and five Program Activities. Section II provides details on departmental performance under each of our Strategic Outcomes and Program Activities.

Health Canada Program Activity Architecture (PAA)

Strengthened Knowledge Base to Address Health and Health Care Priorities

Health Policy Planning and Information

- Health Care Policy
- Intergovernmental Affairs
- Strategic Health Policy
- International Affairs
- Women's Health
- Applied Research Dissemination and Accountability
- Nursing
- Official Language Minority Community Development

Access to Safe and Effective Health Products and Food and Information on Healthy Choices

Health Products and Food

- Pre-market Regulatory Evaluation and Process Improvement
- Information, Education and Outreach on Health Products, Food and Nutrition
- Monitoring Safety and Therapeutic Effectiveness and Risk Management
- Transparency, Public Accountability and Stakeholder Relationships

Reduced Health and Environmental Risks From Products and Substances, and Safer Living and Working Environments

Healthy Environments and Consumer Safety

- Workplace Health and Public Safety
- Safe Environments
- Product Safety
- Tobacco Control
- Drug Strategy and Controlled Substances

Pest Control Product Regulation

- New Pest Control Product Registration and Decision Making
- Registered Pest Control Product Evaluation and Decision Making
- Compliance
- Pesticide Risk Reduction
- Regulatory Improvement

Better Health Outcomes and Reduction of Health Inequalities Between First Nations and Inuit and Other Canadians

First Nations and Inuit Health

- First Nations and Inuit Community Health Programs
- First Nations and Inuit Health Protection
- First Nations and Inuit Primary Health Care
- Non-insured Health Benefits (NIHB)
- Governance and Infrastructure Support to First Nations and Inuit Health System

Strategic Outcomes
Program Activities
Program Sub-Activities

Complementing Health Canada's PAA are departmental medium-term corporate priorities. They encourage integrated attention to key health and management issues that have impacts across multiple strategic outcomes. The priorities also reflect management improvement commitments beyond the scope of the PAA. Links between specific corporate priorities and strategic outcomes are set out in the Summary of Performance table later in this Section. Our **corporate priorities** for 2007-2008 were:

1. Contributing to the improvement of the health of Canadians
2. Reducing the risks to the health of the people of Canada
3. Working with others to strengthen the efficiency and effectiveness of the publicly-funded health care system
4. Strengthening accountability to Parliament and the public

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
3,036.7	4,400.9	4,286.0

Health Canada's expenditures were about $1 billion more than originally planned, due primarily to settlement of compensation payments to individuals infected with the Hepatitis C virus through the Canadian blood supply before 1986 and after 1990.

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
8,825	8,899	74

Operating Environment and Context

Health and safety is a priority of the Government of Canada and Health Canada is the focal point for much of the federal health agenda. Health Canada continued to work closely with Health Portfolio partners and with other federal departments on issues of shared responsibility, such as environmental health, food safety, and improvements to regulatory approaches. Health Canada also collaborated with other partners, including provincial and territorial governments, First Nations and Inuit organizations and communities, professional associations, consumer groups, universities and research institutes, international organizations and volunteers.

Our Department uses a mix of policy development and program delivery activities to carry out our responsibilities. We also use grant and contribution programs to fund partners in the health sector and at the community level to pursue goals such as health system modernization and combating abuse of illicit drugs and controlled substances. To support greater control over their health services, Health Canada also continues to transfer program and service funding and responsibilities to First Nations and Inuit.

The Department's operating environment was much as projected in our *Report on Plans and Priorities*. However, two notable examples demonstrate how the Government and our Department responded to emerging situations.

A number of incidents raised concerns that resulted in recalls of food, health and consumer products. Those situations highlighted gaps in a regulatory framework for protection initially established in the 1950s. It was clear to the Government and Health Canada that the framework did not work as well as needed in a time when Canadians have access to many new products generated by domestic and international producers working through complex supply chains. This changed marketplace, along with the ever increasing pace of innovation, led to prompt action to begin modernizing the **regulatory framework for food, health and consumer product safety** in order to strengthen health protection for Canadians.

Research has shown that some **substances in the environment** may pose health risks such as cancers, asthma and other respiratory illnesses, as well as cardiovascular disease and developmental disorders that may be particularly pronounced for children and for people living in rural and remote areas. The continuing commitment of our Department to conduct research on these substances and to draw on research from other sources led to quick action to prohibit substances such as Bisphenol A which is used in baby bottles.

Summary of Performance in Relation to Departmental Strategic Outcomes and Priorities

Strategic Outcome #1: **Strengthened knowledge base to address health and health care priorities**	
Aligned to Health Canada corporate priorities: 1) improving the health of Canadians; 3) strengthening the health care system; and 4) accountability.	
Program Activity #1: Health Policy, Planning and Information	
2007 – 2008 ***($ millions)***	
Planned Spending	**Actual Spending**
263.7	1,357.2 Variance due to settlement of compensation payment for individuals infected with the Hepatitis C virus
Expected Results	**Performance Status**
Strengthened health system through specific strategies and initiatives and knowledge development and transfer	**Successfully Met. Key commitments met include:** Led the establishment of Patient Wait Times Guarantees with provinces and territories. Continued to implement the Pan-Canadian Health Human Resources Strategy. Facilitated establishment and operations of the Mental Health Commission of Canada. Participated in national and international pandemic preparedness efforts. Began $1 billion in compensation payments to individuals infected with Hepatitis C before 1986 and after 1990. Supported improved access to health services for members of official language minority communities.
Challenges and lessons learned	Federal focus in the National Pharmaceuticals Strategy is on F/P/T collaborative work to enhance system efficiency, while partners continue to focus on securing new federal funding for drug coverage. Introduction of new technologies, as well as the complexity of ethical, moral, cultural and legal issues, delayed the Assisted Human Reproduction regulations. Evaluation of the Health Care Strategies and Policy Contribution Program called for a better performance measurement system and improved strategic governance for better, more widely-shared results

Strategic Outcome #2: **Access to safe and effective health products and food and information for healthy choices**	
Aligned to Health Canada corporate priorities: 1) improving the health of Canadians; 2) reducing risks; and 4) accountability.	
Program Activity #2: Health Products and Food	
2007 – 2008 *($ millions)*	
Planned Spending	**Actual Spending**
257.4	307.9
Expected Results	**Performance Status**
Access to safe and effective health products and food Access to information for healthy choices	**Successfully Met. Key commitments met include:** Developed Food and Consumer Safety Action Plan, as announced in December 2007, to modernize regulatory framework and programming in order to strengthen food, health, and consumer product safety. Exceeded or achieved performance standard targets for new pharmaceutical, generic drug and biologic submissions. Excellent progress made in eliminating the backlog in veterinary drug submissions. Conducted over 900 inspections compared to over 700 last year. Launched the first Food Guide for First Nations, Inuit and Métis. *Canada's Food Guide* translated into 10 languages. More than 180 advisories, warnings and recalls issued to health professionals and the public related to drugs, health products, food and nutrition. High levels of satisfaction expressed among the public and health professionals with departmental information.
Challenges and lessons learned	Review performance for several classes of medical device applications fell below previous year levels due to increased number and complexity of submissions. Review backlogs for natural health products (NHP) continued. Progress expected with 2008 Government investment of $82.5 million over five years. Fewer clinical trial inspections conducted than planned. Evaluations identified areas for action, for example, the Natural Health Products Research program would benefit from more communications, collaboration, coordination and knowledge transfer.

Strategic Outcome #3: **Reduced health and environmental risks from products and substances, and safer living and working environments**	
Aligned to Health Canada corporate priorities: 1) improving the health of Canadians; 2) reducing risks; and 4) accountability.	
Program Activity #3a: Healthy Environments and Consumer Safety	
2007 – 2008 *($ millions)*	
Planned Spending	**Actual Spending**
333.8	334.4
Expected Results	**Performance Status**
Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other	**Successfully Met. Key commitments met include:** Progress made in implementing National Anti-Drug Strategy. Downward smoking trend continued, with more adult Canadians quitting smoking and reduced smoking prevalence among Canadian youth (15-17).

substances	
Reduced risks to health and safety, and improved protection against harm associated with workplace and environmental hazards and consumer products (including cosmetics)	Chemicals Management Plan (CMP) and Clean Air Agenda (CAA) progressed in partnership with Environment Canada. As part of the CMP "Challenge" initiative, 200 substances of highest priority identified, leading to assessments and management plans for substances such as Bisphenol A in baby bottles. Under the CAA, assessments conducted of health risks from indoor and outdoor pollution sources and expansion of monitoring and information tools related to health and the environment. Food and Consumer Safety Action Plan includes a proposed Canada Consumer Product Safety Act.
Challenges and lessons learned	Recruitment and retention of scientific and public health professionals is a challenge being addressed through a people management plan and new staffing processes. An integrated management framework responds to Auditor General calls for improved planning and stewardship of resources, monitoring and reporting.

Program Activity #3b: Pest Control Product Regulation	
2007 – 2008 *($ millions)*	
Planned Spending	**Actual Spending**
50.9	58.9
Expected Results	**Performance Status**
Access to safer pesticides Improved transparency and knowledge dissemination	**Successfully Met. Key commitments met include:** Most new registered pesticide active ingredients were reduced-risk, supported by greater use of collaborative reviews with pest control regulators in other countries. Responsiveness to needs of growers and users for pest control products available to global competitors. Seven regulatory proposal, directions or discussion documents published for consultation.
Challenges and lessons learned	Performance for the registration of new pesticide active ingredients was below targets as a result of increased workload – was addressed with more resources and new hiring.

Strategic Outcome #4: **Better health outcomes and reduction of health inequalities between First Nations and Inuit and other Canadians**	
Aligned to Health Canada corporate priorities: 1) improving the health of Canadians; 2) reducing risks; 3) strengthening the health care system; and 4) accountability.	
Program Activity #4: First Nations and Inuit Health	
2007 – 2008 *($ millions)*	
Planned Spending	**Actual Spending**
2,130.9	2,227.6
Expected Results	**Performance Status**
Improve health outcomes by ensuring the availability of, and access to, quality health services, and supporting	**Successfully Met. Key commitments met include:** Continued to provide a range of health services as well as Non-Insured Health Benefits. Continued to attract new nursing graduates to reduce vacant on-reserve nursing positions. Increased efforts to attract Aboriginal youth to health occupations.

greater control of the health system by First Nations and Inuit	Continued pilot projects for diabetes and for prenatal care, to test wait times improvements for First Nations on-reserve. Prepared a mental wellness strategic action plan and implemented community-based suicide prevention projects. Regional pandemic influenza plans established to support First Nations communities in local preparedness planning. Continued improvement in community drinking water monitoring and advisories. Innovative tripartite health governance approach launched in British Columbia.
Challenges and lessons learned	Ongoing systemic challenges continued e.g. health human resource shortages and costs of serving a rapidly growing population with a higher rate of injuries and disease, living largely in remote and rural areas. Pilot efforts to integrate First Nations health systems with provincial ones showed that successful integration has to be tailored to reflect individual First Nations circumstances.

Progress by Strategic Outcomes for 2007-2008

Strategic Outcome #1: Strengthened knowledge base to address health and health-care priorities

Including the key areas of focus for 2007-2008: Supporting the health care system by advancing Patient Wait Times Guarantees and global health security

Canadians expect to have access to their public health care system when they need it. Through clear federal leadership and facilitated by more than $600 million in funding from the Government of Canada, an agreement was reached with all provincial and territorial governments to establish a **Patient Wait Times Guarantee** in at least one of the priority clinical areas (cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration).

The federal government is acting as a catalyst on this issue. Through an investment of $30 million over three years, it is supporting 10 pilot projects in eight provinces and territories to test and evaluate innovative approaches to establishing guarantees and options for alternate care (recourse) when time frames have been exceeded. These projects are advancing knowledge and best practices for reduction and better management of wait times. In addition, the Government provided $400 million to Canada Health Infoway in 2007 to improve access to health care through innovative application of information and communication technologies.

Canada faces major health threats from **avian and pandemic influenza**. We continued to participate in the government-wide effort that is supported by $1 billion to ensure Canada is well prepared to deal with both threats. Our Department supported the Avian and Pandemic Influenza Preparedness Interdepartmental Governance Agreement to address horizontal issues and

initiatives. We helped facilitate global collaboration in managing threats posed by pandemic influenza and worked with communities and partners to support on-reserve First Nations in development, testing and integration of their pandemic influenza plans.

Another contribution to progress on wait times is improved planning and management of **health human resources.** In collaboration with partners, we supported initiatives that are addressing significant issues such as integration of internationally educated health professionals into Canada's health system.

Mental health issues have broad social and economic impacts on Canadians. In 2007, the Government created the Mental Health Commission of Canada, with a commitment of $130 million over 10 years, to serve as the focal point for a national approach to improve the quality of life for Canadians and their families dealing with mental illness. The Government, through Budget 2008, further committed $110 million to national research projects related to mental health and homelessness.

Our Department continued to work with official language minority communities to help them address their particular health service priorities and to build community networking. Much of this centred on support for training in French-language universities and college health professional programs outside of Quebec, and official languages training for health care workers in Quebec. These efforts were enhanced with an additional $4.5 million announced for initiatives during 2007-2008.

Strategic Outcome #2: Access to safe and effective health products and food and information for healthy choices

Including the key area of focus for 2007-2008: Protecting the health of Canadians with a focus on regulatory renewal and natural health products

The Government is modernizing Canada's regulatory framework and programming for food, health and consumer products to strengthen protection of Canadians' health and safety in today's complex, expanding global marketplace. The focal point of that work is the commitment of $490 million over five years to the **Food and Consumer Safety Action Plan**, announced by the Prime Minister in December 2007. Under the Action Plan, the Government intends to: provide better product information to consumers and guidance to industries to prevent harm; enhance monitoring in targeted areas throughout a product's life cycle to ensure safety; and introduce new regulatory authorities to enable faster action to protect the public. A modernized regulatory framework under the Food and Consumer Safety Action Plan will also ease the burden on industry so it can focus on bringing safe and effective health and consumer products to the market.

Implementation of the Action Plan has begun. A new integrated website, Healthy Canadians, combining recall information from Health Canada and the Canadian Food Inspection Agency, gives Canadians one-stop access to information on all recalled food, health and consumer products. Our Department supported the process leading to the introduction of two bills in the

House of Commons that propose to modernize the regulatory framework to strengthen food and consumer safety: Bill C-51 would amend the *Food and Drugs Act*; and Bill C-52 would create a Canada Consumer Product Safety Act.

Health Canada continued its effort to renew the regulatory framework and programming for **natural health products**, with a view to reducing the application review backlog and further enhancing product safety. We expect more progress this year and beyond, with the 2008 Government investment of $82.5 million over five years.

Close to 14 million copies of the revised *Canada's Food Guide for Healthy Eating* were distributed. Health Canada also offered a new "My Food Guide" interactive tool through the Food Guide website that enables Canadians to obtain personalized food and nutrition guidance. The website received over three million visits; over 14 million pages have been viewed; and 585,000 "My Food Guides" have been created.

Health Canada also developed and launched the first Food Guide for First Nations, Inuit and Métis. In order to assist new immigrants in making healthy food choices, *Canada's Food Guide* was translated into 10 languages.

Beyond these initiatives, we continued to improve the timeliness of our **regulatory decision-making** related to submissions for approval of new pharmaceuticals, medical devices, veterinary drugs and other products. We exceeded or achieved targets in most of these areas, while addressing challenges that remain in others.

Strategic Outcome #3a: Reduced health and environmental risks from health products and substances, and safer living and working environments

Including the key areas of focus for 2007-2008: Advancing health and environmental initiatives; Protecting the health of Canadians through regulatory renewal and implementing the National Anti-Drug Strategy

Regulatory renewal activities under the **Food and Consumer Safety Action Plan**, outlined under Strategic Outcome #2 above, include regulatory renewal and program enhancements to strengthen consumer product safety, which fall under Strategic Outcome #3a.

The **Chemicals Management Plan** and its federal investment of $300 million**,** has positioned Canada as a global leader in safe management of chemical substances and products. We continued to collaborate with Environment Canada to advance implementation. Our focus was primarily on reassessing chemicals introduced to the Canadian marketplace in years past, based on the most current knowledge about health risks. This has led to action to manage the risks associated with substances confirmed to be harmful to human health or the environment, such as the chemical Bisphenol A, when it is used in the manufacture of polycarbonate baby bottles. Action is also pending on an additional 193 chemicals that are potentially harmful.

Our Department advanced the Government's **Clean Air Agenda**, including assessment of health risks from indoor and outdoor air pollution sources. We also completed the indoor air quality guideline for ozone and carbon monoxide, developed a priority list of indoor air contaminants, contributed to development of ambient air regulations, and performed an initial health economic analysis of the benefits of proposed regulations.

An example of this work is the Air Quality Health Index initiative, through which people in Toronto and 14 communities in British Columbia started to receive a daily measure of air quality, enabling them to make informed decisions about their exposure to air pollution and its potentially harmful effects. More Canadians will benefit from the initiative over time.

The **National Anti-Drug Strategy**, announced in 2007, is a collaborative effort involving Health Canada, the Department of Justice, and Public Safety Canada. The Government has invested $300 million over five years in the initiative, focusing on preventing illicit drug use, treating Canadians with illicit drug dependencies, and combating production and distribution of illicit drugs. We led development of the prevention and treatment streams of the Strategy. Our Department also funded communities and organizations to implement promotion/prevention measures aimed at abuse of illicit drugs and controlled substances, especially among vulnerable populations such as youth and Aboriginal people.

Strategic Outcome #3b: Reduced health and environmental risks from health products and substances, and safer living and working environments

In addition to our ongoing implementation of the new *Pest Control Products Act*, the first **global joint review** for registration **of new pesticides** was completed in collaboration with the United States, United Kingdom, Ireland, Italy, Australia, New Zealand and Japan. Our participation in this kind of international regulatory cooperative activity provides Canadian growers with access to new pesticides at the same time as their global competitors. Our use of other cooperative mechanisms such as joint review, work sharing and effective utilization of foreign evaluations has enabled Canadian users to gain **timely access to new, reduced-risk products**. International collaboration resulted in registration of three new pesticide active ingredients.

An ongoing concern for Canadian pest control product users is the number of products available in the United States and elsewhere with likely uses that are too limited in Canada to encourage manufacturers to seek Canadian registration for "minor uses." To address this proactively, we carried out work that led to registration of 758 new minor uses. We are working with the U.S. Environmental Protection Agency and other regulatory agencies to expand the use of joint reviews and work sharing to address minor uses further.

Strategic Outcome #4: Better health outcomes and reduction of health inequalities between First Nations and Inuit and other Canadians

Including the key area of focus for 2007-2008: Improving the health of specific populations

Much of our work was ongoing delivery of services such as primary care and community/home care, as well as programs focused on enhancing maternal and child health, mental wellness, suicide prevention, chronic disease and injury prevention, communicable disease readiness and environmental health. We also continued to provide Non-Insured Health Benefits to approximately 800,000 eligible First Nations and Inuit covering medically necessary health-related goods and services not provided through private or provincial/territorial health insurance plans.

We also pursued priorities designed to help improve First Nations and Inuit health outcomes and health services. Health Canada partnered with provinces, territories, Aboriginal communities, and other federal departments to ensure availability of and access to quality health care for First Nations and Inuit. We continued implementation of 20 pilot projects to explore ways to reduce patient wait times for prenatal and diabetes care. We also continued initiatives that are improving our ability to attract and retain employees who provide front-line health services and that are encouraging Aboriginal people to pursue health careers.

The Government has been implementing drinking water quality standards for First Nations water systems. Since 2006, the number of high-risk water systems in First Nations communities has been reduced by half. We also began planning how best to enhance this progress as a result of the federal investment of an additional $330 million in water and wastewater management beginning in 2008-2009.

Because of our responsibility for health services to First Nations on-reserve, we developed regional approaches designed to support local planning for avian and pandemic influenza that will align with the planning for their neighbouring communities, health regions and provinces.

We implemented a visionary and strategic plan that will not only renew the First Nations and Inuit health system, but will completely change the way First Nations and Inuit health services are delivered, through innovative partnerships, integration with provincial health systems and, most importantly, increased ownership for First Nations and Inuit communities. Canada's first Tripartite First Nations Health Plan was signed in 2007 between the Governments of Canada and British Columbia and the First Nations Leadership Council. Under the Plan, the partners are working towards a new governance structure that will enhance First Nations involvement in delivery of health services, and promote better integration and coordination of federally and provincially-funded health services. We also explored the possibility of similar tripartite agreements with other provincial partners and First Nations, recognizing that successful agreements have to reflect the diverse situations of First Nations across Canada.

Progress on Departmental Management Priorities

Activities under Health Canada's Corporate Priority 4, "Strengthening accountability to Parliament and the public", took place across all program activities set out in the Program Activity Architecture. The activities centre on departmental responses to government-wide initiatives such as the *Federal Accountability Act*, the *Public Service Modernization Act* (PSMA), the Management Accountability Framework (MAF) and strengthened resource management and performance measurement/reporting in relation to regulatory programs.

Treasury Board Secretariat conducted an assessment of Health Canada's **Management Accountability Framework** during 2007. As a reflection of activities undertaken to strengthen management practices, the resulting MAF ratings indicated that we achieved considerable improvements over previous years.

In her November 2006 Annual Report (Chapter 8), the Auditor General made recommendations on allocating funds to regulatory programs. We made significant progress to address those recommendations through a management action plan centred on branch-level **Comprehensive Reviews** to benchmark regulatory program performance and resource requirements and a corporate **Financial Management Control Framework**. We continued to work on the Comprehensive Reviews for all regulatory programs leading to establishment of new performance measurement frameworks. We also accelerated development and implementation of the Financial Management and Control Framework, with notable progress in budget management, financial management accountability, and the state of readiness for audited financial statements, scheduled for 2008-2009.

Health Canada continued to support the Government's Response to the **Blue Ribbon Panel Report on Grant and Contribution Programs.** The Health Portfolio Action Plan was established and identifies initiatives that address recommendations of the Report. These include a risk management framework for grant and contribution program activities, an automated grant and contribution management system, a supporting Intranet site and adoption of simplified administrative procedures.

The Department also enhanced **contract management** by ensuring that solid governance structures and administrative processes are in place. As well, our Department implemented Phase 1 of an automated Contract Requisition and Reporting System to enhance contract administration controls.

We responded to the government-wide commitment to **integrate human resources and business planning** with a plan that we published in March 2008. This was a first step toward full integration of human resources, strategic and operational planning processes by 2009-2010 and a longer term commitment to a department-wide integrated planning framework.

Consistent with Treasury Board's **Management, Resources and Results Structure** (MRRS) initiative, our Department revised its Program Activity Architecture (PAA), defined the

Performance Measurement Frameworks and Governance Structure for the entire PAA, and began the systematic creation, capture and use of MRRS information. Furthermore, we have successfully developed a set of common results statements and indicators for our regulatory branches and have aligned, where possible, the phrasing of branch results statements and indicators in the MRRS with this wording.

The Department continued to focus on developing guidelines and tools to improve the quality and results focus of evaluations, including piloting the "value for money" tool developed by Treasury Board Secretariat. We also enhanced our review of performance measurement and evaluation strategies outlined in Treasury Board submissions and Memoranda to Cabinet.

Section II

Analysis of Performance by Strategic Outcome

STRATEGIC OUTCOME #1

Strengthened Knowledge Base to Address Health and Health Care Priorities

Program Activity Name:
Health Policy, Planning and Information

Expected Results:
Strengthened health system through:

- Goals and objectives identified for specific strategies and initiatives; and
- Knowledge development and transfer of specific health policy issues

Health Risk/Outcome Area: A strengthened health system	
Performance Indicators	**Results**
Establishment of F/P/T strategies and commitments	Led development of Patient Wait Times Guarantees (PWTGs) with provinces and territories and launched PWTG Pilot Project Fund. Implemented the Pan-Canadian Health Human Resources (HHR) Strategy. $400 million allocated to Canada Health Infoway to advance patient access and quality care through electronic health records (EHRs) and other innovations. Facilitated establishment and operations of the Mental Health Commission of Canada.
Action on specific health policy commitments	Began payments under the pre-1986/post-1990 Hepatitis C Settlement Agreement. To improve access to health services for official language minority communities, 3,181 students registered in French-language university and college health professional programs funded outside of Quebec (2003-08), and official languages training provided to 5,360 health care workers (2005-08) in Quebec.
Draft legislation and regulations released	Assisted Human Reproduction Regulations for consent to use gametes and embryos came into force on December 1, 2007. Proposed legislation to support the Food and Consumer Safety Action Plan completed for tabling in Parliament in April 2008. Achieved an 18% reduction under the Paperwork Burden Reduction initiative; on track to the 20% target by November 2008.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
263.7	1,399.2	1,357.2

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
588	540	48

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:

- Settlement of compensation payments for individuals infected with the Hepatitis C virus through the Canadian blood supply before 1986 and after 1990
- Funding for Canada Health Infoway
- Funding for the Canadian Institute for Health Information (CIHI)
- Funding for Patient Wait Times Guarantees
- Funding for Rick Hansen Foundation
- Funding for the Mental Health Commission of Canada

Variances between actual spending and total authorities are mainly due to:

- Lapse in the Health Council special purpose allotment
- Reprofile of some Canadian Strategy for Cancer Control funds to future years
- Other lapses in programs

Canadians look to their federal government for leadership and partnership with others in support of a strong, accessible health system for all Canadians. Under this program activity, we provide a leadership role by developing policy responses to issues of importance to the health of Canadians and addressing specific issues in the health system. We routinely do so in collaboration with members of the Health Portfolio and other federal departments, provincial and territorial Ministries of Health, and non-governmental, professional, research, and international organizations. With those partners and independently, we promote and support national coordination and development of a strong, shared knowledge base on health issues. We support research and analysis to facilitate health system adaptation to societal, technological, industrial and environmental changes so that Canadians are protected from health risks, have access to quality health care, and gain positive health benefits from information and innovation.

We achieve these objectives through our own actions and through grants and contributions to partners. Our efforts include: managing funding programs to stimulate health system research and renewal, administering the *Canada Health Act*, drafting legislation and regulations, developing and distributing federal position papers on emerging issues, and providing policy advice to the Minister.

During the year, we made important progress on two major issues that we had identified as priorities in the *Report on Plans and Priorities* (RPP). The first was to move forward on the Government's Patient Wait Times Guarantees and to collaborate with our partners in tackling key factors in health system improvement: a health human resources strategy, technological innovation and health care system research. The second was to continue coordinating and improving pandemic influenza preparedness and response in Canada and contributing to international progress on the issue. In the RPP, we also committed to support renewed health protection legislation and modernization of the related regulatory system to enhance the safety of consumers, patients and workers. Much of that work helped pave the way for the Food and Consumer Safety Action Plan that is described under Strategic Outcomes 2 and 3, later in this Section.

Health Care Policy

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
146.2	172.6	169.7

Expected Results: Improved access, quality and integration of health care services for all Canadians	
Performance Indicators	**Results**
Establishment of F/P/T strategies and commitments Interim and summative evaluations of funding programs Progress reports on health care renewal from the Health Council	Supported development of Patient Wait Times Guarantees (PWTGs) to provide patients with greater certainty of timely access to quality health care services. Launched the PWTG Pilot Project Fund. Funded initiatives that promote planning and management of Health Human Resources (HHR) as part of the Pan-Canadian HHR Strategy Continued to implement the Internationally Educated Health Professionals Initiative: 27 multi-year contribution agreements support over 50 initiatives. Developed an action plan following completion of an evaluation of the Primary Health Care Transition Fund (PHCTF). Continued to support the Health Council's monitoring and reporting role in implementation of the 2003 and 2004 Health Accords. Supported initiatives to improve Canadians' access to quality health care through development and sharing of knowledge and resources. Facilitated establishment of the Mental Health Commission of Canada. Began payments to eligible applicants for the pre-1986/post-1990 Hepatitis C Settlement Agreement.

There were six major areas of importance to Canadians under the Health Care Policy sub-activity.

Wait Times Management and Health Care Renewal

The Health Council of Canada, the Wait Times Alliance and the Canadian Medical Association all report that progress is being made in reducing wait times within the five priority areas identified in the 2004 Health Accord – cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration. The efforts and investments of all governments, and of health care institutions and providers across the country, have contributed to this important progress.

Our highest profile priority was to support development of Patient Wait Times Guarantees (PWTGs) to provide patients with greater certainty of timely access to quality health care services. Following the agreement of each provincial and territorial government to establish a PWTG by March 2010, we launched the PWTG Pilot Project Fund. With this Fund, interested provinces and territories are testing and evaluating innovative approaches to establishing

PWTGs, including options for alternate care (recourse) when established time frames have been exceeded. These projects will help provincial and territorial governments develop guarantees that will move the health system toward more responsive, patient-centred care. For our part, we continued to directly support and oversee four pilot projects: three to establish guarantees for diabetes and prenatal care in selected First Nations communities and a fourth for paediatric surgical wait times.

Under the National Wait Times Initiative (NWTI),[2] Health Canada partnered with stakeholders in supporting research, knowledge development and dissemination in order to inform policies, programs and services aimed at improving access to care and reducing wait times. Work sponsored included: a roundtable and research paper on mental health wait times, a workshop to share a synthesis of wait times research by the Canadian Institutes of Health Research (CIHR), and a "Taming of the Queue" Conference.

Our Department continued to support the Health Council's monitoring and reporting role concerning implementation of the 2003 and 2004 Health Accords. The Council published its third annual report, as well as issue-specific reports with more detailed analysis of issues such as primary health care and home care. It also released: Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions and Why Health Care Renewal Matters: Lessons from Diabetes.

The Department renewed support for the Canadian Patient Safety Institute (CPSI)[3] for a further five years, with funding of up to $8 million per year. This will enable CPSI to continue to provide leadership, foster collaboration and promote improvements in patient safety and quality of care.

Health Human Resources Strategies

Health Canada continues to implement the Pan-Canadian HHR Strategy,[4] which provides up to $20 million annually for activities that promote planning and management of HHR. These activities are meant to ensure that Canadians have access to the health providers they need. The Strategy includes three initiatives: Pan-Canadian HHR Planning; Interprofessional Education for Collaborative Patient-Centred Practice; and Recruitment and Retention.

Our Manitoba/Saskatchewan Region organized four Canada Manitoba Health Policy Dialogue discussions on health policy topics of mutual interest. They included the University of Manitoba's Northern health care programs and the application of gender-based analysis to health services.

Much of our support involved funding to stakeholder-driven initiatives. For example, we are collaborating with Statistics Canada to assess and report on statistics related to the education of health professionals in Canada to examine the reasons for attrition. The Department also supported the Association of Faculties of Medicine of Canada's review of undergraduate medical

[2] http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index-eng.php
[3] http://www.hc-sc.gc.ca/hcs-sss/qual/patient_securit/cpsi-icsp-eng.php
[4] http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/init-prof-educ-eng.php

education in Canada to promote excellence in patient care. We funded the Canadian Federation of Nurses Unions to identify measures that unions and employers can undertake together to promote quality work life practices that will improve retention and recruitment of nurses and the quality of patient care.

In partnership with governments, regulatory bodies, and academic organizations, Health Canada continues to implement the Internationally Educated Health Professionals Initiative (IEHPI),[5] for which the federal government committed $75 million over five years, beginning in 2005-2006. The goal is to facilitate integration of health professionals educated in other countries into the Canadian work force. Provinces, territories, and non-governmental organizations have funding for 27 agreements that are supporting over 50 initiatives, often designed to achieve a more standardized approach to assessing international graduates. Highlights include an innovative competency assessment centre for internationally educated nurses in Alberta, now being expanded across the country, and a faculty development program for teachers of international medical graduates, that was fully implemented in all 16 Canadian medical schools.

An evaluation of the Health Care Strategies and Policy Contribution Program, which includes delivery of the Pan-Canadian HHR Strategy, the IEHPI, the NWTI and the PWTG Pilot Project Fund was completed in December 2007. It found that the Program addresses issues relevant to today's health care system and provides a flexible mechanism to address emerging health care issues quickly. However, it also recommended a more objective-oriented performance measurement system, improved information dissemination and knowledge transfer mechanisms; and improved strategic governance of the Program to better inform allocation decisions, increase coordination and collaboration of and between projects and foster broadened application of project results. We are drawing on these results as the Program moves forward.

Home and Continuing Care, Chronic Disease Management, e-Health

Electronic health records (EHRs)[6] are an important tool in improving quality, safety and accessibility of health care. The Department invested an additional $400 million in Canada Health Infoway Inc. to support continued implementation of EHRs and improvements to patient access and quality care. We also participated in an Organisation for Economic Co-operation and Development initiative examining successful strategies for implementation of EHRs. Health Canada supported research and analysis on how best to improve integration of health care. We also supported development of a guide for regional health authorities who choose to introduce advance care planning programs, which will be available in 2008-2009.

Recognizing growing concerns about autism and interest in addressing it, we provided $1 million over five years to Simon Fraser University for a Research Chair on Autism Treatment and Intervention, in collaboration with the Government of British Columbia. We also improved our website content related to autism and supported the Canadian Autism Intervention Research Network to update research information available to the public and ensure its availability in both official languages.

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[5] http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/init-prof-educ-eng.php

[6] http://www.hc-sc.gc.ca/hcs-sss/ehealth-esante/ehr-dse/index-eng.php

Health Canada continued to support the Government's implementation of the Canadian Strategy for Cancer Control, through funding of up to $50 million a year to the Canadian Partnership Against Cancer Corporation and through support for an ongoing policy dialogue with Australia on national cancer control approaches.

We conducted a final evaluation of the Primary Health Care Transition Fund (PHCTF).[7] The Fund (2000-2006) supported provinces, territories and other health care system stakeholders as they developed and implemented initiatives such as interdisciplinary teams of providers and improvements in access, health promotion, disease and injury prevention, chronic disease management, quality of care, accountability, and integration of services. The evaluation found that the PHCTF had been a significant catalyst for primary health care system reform and renewal. It also generated recommendations that resulted in a management action plan.

Mental Health

The Department facilitated establishment of the Mental Health Commission of Canada.[8] Announced in Budget 2007 and officially launched by the Prime Minister in August 2007, the Government committed $130 million over 10 years to enable the Commission to serve as the focal point for mental health and mental illness. Budget 2008 committed an additional $110 million to support the Commission's national research projects related to mental health and homelessness. Since its establishment, the Commission has: established its governance structure and organizational design, including a Board of Directors and eight Advisory Committees; developed governance and administrative policies, and hired senior staff; conducted consultation sessions with stakeholders across Canada, launched studies and start-up activities; and, developed a five-year business plan.

Hepatitis C

Following completion of the pre-1986/post-1990 Hepatitis C Settlement Agreement, payments were initiated for eligible applicants.

Pharmaceuticals Management

In the RPP, we outlined plans for continued work with the provinces and territories on elements of the National Pharmaceuticals Strategy (NPS). The federal focus on the NPS continues to emphasize the importance and value of federal-provincial-territorial (F/P/T) collaborative work on drug utilization, management and costs to enhance system efficiency, health outcomes and equity, while supporting sustainability. As provincial and territorial governments continue to focus on securing new federal funding for drug coverage, progress on the NPS has been challenging, and governments will need to determine how best to continue collaboration on shared pharmaceuticals issues. Despite this, plans outlined in the RPP have been largely realized:

[7] http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index-eng.php
[8] http://www.mentalhealthcommission.ca/mhcc-en.php

- Options for Catastrophic Drug Coverage (CDC) have been analyzed and costed. Recent expansions in provincial public drug coverage appear to have been based, in part, on this work.

- In the NPS priority area, Expensive Drugs for Rare Diseases, we continued our collaboration on the three-year Canadian Fabry Disease Initiative Study (CFDI).[9] While focusing on a single rare disease, the study's aim is to inform how we can best assess the effectiveness of *all* rare disease drugs, and make evidence-based decisions on public reimbursement for these drugs.

- Under the NPS element, Common Drug Formulary, we collaborated with officials from F/P/T drug plans to provide advice and policy direction to the Canadian Expert Drug Advisory Committee (CEDAC)[10] in support of expansion and improvement of the F/P/T Common Drug Review (CDR),[11] whose recommendations inform public drug reimbursement in all provinces (except Quebec, which does not participate in the NPS or CDR).

- We contributed to the Government Response to the 2007 Study of the CDR by the House of Commons Standing Committee on Health, which found that participating drug plans view the CDR as a positive example of intergovernmental cooperation that provides valuable service to the public.[12] The Canadian Agency for Drugs and Technologies in Health (CADTH)[13] is responsible for the CDR as well as the Canadian Optimal Medication Prescribing and Utilization Service. A 2007 third-party evaluation of CADTH's performance indicated that participating F/P/T drug plans view the CDR's impacts as "entirely positive,"[14] and internal monitoring and analysis at CADTH confirms that the CDR has decreased overlap and duplication, increased efficiency, consistency and decision-making rigor, and has resulted in a more than 90 percent uptake of listing recommendations by F/P/T drug plans.

- In the Drug Pricing and Purchasing priority area of the NPS, and pursuant to previous agreements by F/P/T Health Ministers, we funded the Patented Medicine Prices Review Board (PMPRB) to monitor and report on non-patent and off-patent prescription drug sales and pricing indicators.[15]

- For the Real World Drug Safety and Effectiveness element of the NPS,[16] we collaborated with partners to develop a business plan that proposes a virtual network to link Centres of Excellence in post-market drug safety and effectiveness research in order to close evidence gaps and develop needed research capacity. Provinces and territories have expressed interest in sharing data to support such a network.

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[9] http://www.cihr-irsc.gc.ca/e/35803.html
http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2006/2006_48-eng.php

[10] CEDAC is the committee of experts that makes the CDR recommendations.

[11] http://www.cadth.ca/index.php/en/cdr

[12] http://cmte.parl.gc.ca/cmte/CommitteePublication.aspx?COM=13189&Lang=1&SourceId=228685

[13] http://cadth.ca/

[14] http://www.cadth.ca/index.php/en/cadth/corporate-profile/ekos-evaluation

[15] http://www.pmprb-cepmb.gc.ca/english/view.asp?x=496

[16] http://www.hc-sc.gc.ca/hcs-sss/pharma/nps-snpp/securit/index-eng.php

Nursing

Health Canada works with provincial and territorial principal nursing advisors, federal government nursing colleagues, and national nursing organizations to address priority policy concerns.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
3.7	3.7	3.6

Expected Results: Optimize the contribution of nursing knowledge and practice to improve health care for Canadians	
Performance Indicators	**Results**
Progress on nursing policies and practices (as specified in work plans and funding agreements)	Strengthened role of nurses in health care system through consultation and advice. Contributed to broad evidence-based policy work by: 1) supporting and participating in research; 2) producing policy papers; and 3) linking research and practice with health care providers. Facilitated F/P/T linkages through national committees and meetings.

To address opportunities for nursing knowledge and practice to improve health care we:

- produced policy papers on emerging nursing roles such as those on mandatory nurse-to-patient ratios for staffing, new nursing roles (e.g. nurse anaesthetists), patient safety in mental health settings, the costs of employee turnover and a national birthing strategy;
- developed with partners the NurseONE National Nursing Portal – a bilingual electronic gateway through which nurses can access professional resources and services;
- supported the activities of a national group leading efforts to improve the quality of worklife for nursing and other health professionals. In addition to developing a National Action Strategy and national quality of worklife standards, the group has developed a website and held a national summit, both promoting knowledge exchange, leading to improved awareness of the importance of a healthy healthcare workplace;and
- worked with provincial governments and professional organizations to facilitate a Pan-Canadian approach to increase the number of nurse practitioners.

As part of promoting the healthy workplace as a component of the Pan-Canadian Health Human Resources Strategy:

- we supported projects to improve the health and well-being of front-line health care workers;
- we funded the National Expert Committee on Interprofessional Education, and funded and supported the Canadian Interprofessional Health Collaborative to facilitate knowledge transfer and networking activities.

Assisted Human Reproduction Canada Act Implementation

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
3.1	3.1	3.0

Expected Results: Implementation of *Assisted Human Reproduction Act* and development of related regulations Set-up of Assisted Human Reproduction Canada (AHRC)	
Performance Indicators	**Results**
Progress on regulatory work (milestones established in yearly work plans) Ultimately, AHRC will report on success in promoting health and safety of those using these technologies	Regulations for consent to use gametes and embryos were published in *Canada Gazette Part II* in June 2007 and came into force on December 1, 2007. Drafting instructions for regulations for 13 topics were completed and regulations are being drafted. Drafting instructions for health reporting information regulations are expected to be published in *Canada Gazette Part I* in 2008. The Personal Health Information Registry database was transferred to AHRC in July 2007.

By developing regulations for the Assisted Human Reproduction (AHR) sector, Health Canada is protecting against risks and injuries to health, safety, rights and dignity of Canadians. We continued to engage stakeholders on an ongoing basis to balance the needs of persons who use these technologies with those of children born from these technologies, and providers of these services and society as a whole. During 2007 - 2008 we continued with development of AHR regulations to address the complex social and ethical and health and safety risks raised by these technologies. After consideration of the legal and policy impacts of the Quebec Court of Appeal opinion regarding the constitutionality of the *AHR Act*, a decision has been taken to launch an appeal before the Supreme Court of Canada to clarify any uncertainties.

Assisted Human Reproduction Canada (AHRC) was established in 2006 to administer the *Assisted Human Reproduction Act*. Once regulations are finalized and published, AHRC will be responsible for their implementation and enforcement, and for reporting of information regarding the health and safety of Canadians using AHR technologies. In addition, we began a review of the Processing and Distribution of Semen for Conception Regulations, which fall under the *Food and Drugs Act*, with a view to incorporating these requirements under the AHR.

Health Sciences Policy

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
2.6	2.6	2.4

Expected Results: Contributions to action on specific health science issues	
Performance Indicators	**Results**
Reflection of ethical, legal, social, economic and health system considerations in international and domestic partnerships and in policy advice in health science areas. Progress on a system for human research protection (milestones specified in work plan and project agreement)	A workshop was held and a policy report commissioned on the impact of licensing in human genetics on the uptake of new diagnostics in the health system. Research on intellectual property in HIV/AIDS vaccine technologies addressed how patent protection may affect research. A forum enabled federal departments to share experiences on challenges in vaccine development and uptake. Engaged and supported the Sponsors' Table (ST) for Human Research Participant Protection in Canada, which established an Experts Committee to recommend improvements for human research participant protection. Completed year two of a stakeholder-driven process to develop a voluntary standard for research ethics boards that review clinical trials to improve research consistency and efficiency and better protect participants in clinical trials in Canada. A plan was developed to collect data on quality assurance mechanisms in Canadian laboratories conducting genetic testing, and on work to be completed in 2008-2009 to disseminate and encourage uptake of Organisation for Economic Co-operation and Development (OECD) Guidelines on Quality Assurance in Molecular Genetic Testing.

Our health science policy efforts took many forms beyond the points noted in the box above. One focus was improved quality assurance and technology transfer in human genetics. We took part in two OECD initiatives to develop international guidelines regarding (1) management of intellectual property in human genetics, and (2) measures to ensure quality in genetic testing. These initiatives will improve access to and the quality of gene-based health technologies. We contracted leading researchers to provide the Department with a road map for implementing the guidelines, and engaged laboratory directors, offices of technology transfer, university researchers, administrators and the private sector in a dialogue on the principles endorsed in the intellectual property guidelines. These initiatives advanced the Government's commitments in the Science and Technology Strategy related to intellectual property management and regulatory supports for innovative health technologies.

Another focus was our work with partners in early issue identification and monitoring of emerging technologies, including nanotechnology, and policy research on potential ethical, legal and social impacts. As part of this, we mapped the ethical, legal and social nanotechnology research in Canada in an effort to identify major stakeholders and other potential partners. We also identified goals for specific strategies to maximize benefits and minimize/prevent harm associated with new technologies.

Health Canada conducted policy research and analysis on the ethical conduct of research involving humans, regulations for protecting human research participants, and standards for research ethics boards reviewing clinical trials. The Department joined partners to examine

models of accreditation for human research protection in Canada. Health Canada also strengthened international linkages and harmonized practices through support and promotion of the UNESCO Declaration on Bioethics and Human Rights and by playing a lead role in OECD efforts to develop Guidelines for Human Biobanks and Genetic Research Databases. These activities contributed to the departmental goal of strengthening F/P/T linkages in human research participant protection, as well as federal efforts to improve the health of specific populations and to reduce health risks through collaboration with other governments.

Legislative and Regulatory Affairs

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
2.2	2.2	2.0

Expected Results: Better protection for the health and safety of consumers, workers, and patients	
Performance Indicators	**Results**
Progress towards regulatory policy coherence across the Health Portfolio Achievement of milestones towards completion of a new framework set in annual work plans (as stated in RPP) The success of the new health protection framework will be reported on by departmental Branches and Health Portfolio organizations responsible for specific sectors e.g. food safety, consumer safety	Established a Portfolio-wide steering committee on implementation of the Cabinet Directive on Streamlining Regulation (CDSR). Began to improve the regulatory process. Progress was made in performance measurement and cost benefit analysis, with results anticipated for 2008-2009. Achieved an 18% reduction under the Paperwork Burden Reduction initiative; on track to the 20% target by November 2008. Developed a prioritization criteria and governance model, to efficiently channel legislative and regulatory activity.

We supported the departmental process that led to development of proposed amendments to the *Food and Drugs Act* and a new Canada Consumer Product Safety Act that were tabled in Parliament on April 8, 2008 and are discussed under Strategic Outcomes 2 and 3. We also continued to work on legislative policy related to Health Canada and Public Health Agency of Canada (PHAC) collection, use and disclosure of personal information, as well as radiation emitting devices and passenger conveyances.

Our continued work to improve regulatory processes was in keeping with the Cabinet Directive on Streamlining Regulation and associated Treasury Board guidelines. We made good progress in implementation, including a new requirement for performance measurement of regulatory initiatives. Our Department also ensured greater internal efficiencies in regulatory development and a reduction in unnecessary administrative burden on business. We continued to work on measures under the Paperwork Burden Reduction Initiative.

International Affairs

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
28.0	28.1	9.0*

*Variance is due to the requirement to provide advance payment of international membership fees.

Expected Results: Contribute to enhancing global health security and protecting the health of Canadians	
Performance Indicators	**Results**
Participation in and outcomes of conferences and meetings; establishment of joint strategies and frameworks Expected results and performance measurements relating to specific sectors will be reported on by the organizations responsible e.g. PHAC will report on pandemic preparedness	Health Canada participated in the Eighth Ministerial Meeting of the Global Health Security Initiative (GHSI). Participated in World Health Organization's Intergovernmental Working Group on Public Health Innovation and Intellectual Property. Initiated an international workshop on reducing risks to human health posed by animals.

Canada is an active contributor to health initiatives on the international stage.[17] Our priority was to collaborate with partners such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) on pandemic influenza preparedness, HIV/AIDS and global health security.[18] We also built our relations with countries such as China, which led to a new Canada-China Joint Committee on Health to highlight areas of future collaboration pertaining to health systems reform, financing of pharmaceuticals, and primary rural health care.

In November 2007, we participated in the Eighth Ministerial Meeting of the Global Health Security Initiative (GHSI), an informal partnership of the G7 countries plus Mexico, to strengthen public health preparedness and response globally to the threat of international chemical, biological and radio-nuclear terrorism.

As a result of issues raised by some developing countries coping with H5N1 avian influenza outbreaks, we supported the 2007 World Health Assembly decision to establish the Intergovernmental Meeting on Pandemic Preparedness that worked to ensure ongoing sharing of virus samples, to establish an international stockpile of vaccines, and to explore mechanisms and guidelines for distributing pandemic influenza vaccines.

Our role in the WHO Intergovernmental Working Group on Public Health Innovation and Intellectual Property included hosting a consultation with 28 countries of the Americas to explore positions and priorities; and supporting the WHO to strengthen its technical capacity on public health intellectual property issues, producing an expert paper on patent issues related to influenza viruses.

[17] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/iad-dai/index-eng.php
[18] http://www.hc-sc.gc.ca/ahc-asc/intactiv/index-eng.php

The Department initiated a workshop with domestic and international partners on veterinary public health. The workshop exchanged information on best practices and identified strategies for greater integration between health and agricultural expertise in the Americas to reduce risks to human health posed by animals.

Intergovernmental Affairs

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
5.6	5.6	5.1

In addition to our ongoing responsibilities,[19] we administered the *Canada Health Act*, investigating potential cases of non-compliance and analyzing emerging issues of relevance, such as patient charges for primary care in private facilities, possible extra-billing by physicians and charges for surgical services by private clinics. We continued to see a high level of provincial and territorial compliance that we described to Parliament and Canadians in the *Canada Health Act* Annual Report.[20]

Applied Research, Dissemination and Accountability

Health Canada coordinates development of useful and timely health information to Canadians, partners and stakeholders for health policy decision-making, and performance measurement and reporting, as directed by First Minister Health Accords.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
36.5	91.9	62.4*

* Variance is due primarily to the lapse of a portion of the new funding authorized for the Canadian Institute for Health Information.

Focused research that addresses the specific needs of Health Canada and other policy makers is important for good decisions.[21] A good example of this was our continued production of the Health Policy Research Bulletin, which provides public and health sector decision-makers with in-depth evidence about health policy concerns. The latest issue explored factors affecting the health status of people in urban and rural settings. An important element of our spending was funding for the Canadian Institute for Health Information (CIHI) to collect and publicly report data on the health care system.

Of importance to other groups within Health Canada, we developed a variety of health human resource forecasting models, micro-simulation models, and associated databases to enable quantification and analysis of possible policy options and program changes. For example, a

[19] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/index_e.html
[20] http://www.hc-sc.gc.ca/hcs-sss/medi-assur/res/ar-ra-eng.php
[21] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/arad-draa/index-eng.php

microsimulation model measured the fiscal impact on families and individuals of changes to drug and dental program parameters in the context of a sustainability policy review. We also developed a physician supply and demand model that helped to gauge the impact of various policy levers (e.g. more graduates, immigration, retention) to close gaps by physician specialty in Nova Scotia. This model allows planners in all provinces to assess and act on their own physician supply and demand needs. Other activities enabled an assessment of the fiscal impacts on households of a potential pan-Canadian catastrophic pharmacare program. We also completed research that determined the relative importance of factors contributing to nurse absenteeism, in order to facilitate development of strategic policy responses.

Official Language Minority Community Development

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
25.7	25.8	33.5

Expected Results: Improved access to health services for official language minority communities	
Performance Indicators	**Results**
Evaluations of funding programs (Expected results and indicators are specified in funding agreements for projects)	Began evaluation of the Contribution Program to Improve Access to Health Care Services for Official Language Minority Communities. Between 2003-2004 and 2007-2008, 3,181 students had registered in French-language university and college health professional programs funded outside of Quebec (230 graduated by March 31, 2008). Within Quebec, training provided to 5,360 health care workers (2005-2008) – English-language training to French-speaking health care workers to improve services for the Anglophone minority population, and French-language training to English-speaking workers to retain them in the Quebec labour force.

The Contribution Program to Improve Access to Health Services for Official Language Minority Communities continued to provide support for training and retention of health professionals and community networking among English-speaking communities within Quebec and French-speaking communities elsewhere in Canada. In addition to the program data noted in the box above, since 2003, 28 minority language health networks have been created, many of which are now officially recognized by their provincial/territorial governments.

In October 2007, the Minister announced an additional $4.5 million for initiatives to improve access to health services in official language minority communities during 2007-2008.

Results of a Survey on the Vitality of Official Language Minorities were released in December 2007. The survey, a partnership involving Health Canada and nine other government departments, found that 65 percent of French-speaking adults in all provinces except Quebec indicated that the main reason it would be difficult to get health care services in French is the scarcity of French-speaking professionals. In Quebec, 70 percent of English-speaking adults cited a similar problem in receiving services in English.[22]

[22] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/olcdb-bdlo-eng.php

STRATEGIC OUTCOME #2:

Access to Safe and Effective Health Products and Food and Information for Healthy Choices

Program Activity Name:
Health Products and Food

Expected Results:

- Access to safe and effective health products and food
- Access to information for healthy choices

Health Risk/Outcome Area: Access to safe and effective health products	
Performance Indicators	**Results**
Number of instances of unsafe drug alerts (advisories, warnings) and health product recalls issued on the Health Canada website	42 advisories, warnings and recalls for drugs and health products disseminated to health professionals compared to 41 last year. 124 advisories, warnings and recalls for drugs and health products disseminated to the public compared to 96 last year. 21 advisories, warnings and recalls for food and nutrition disseminated to the public compared to 18 last year.
Number of inspections	Over 900 inspections conducted.
Percentage of compliance based on total number of inspections (of establishments) completed	98% compliance
Percentage of new pharmaceuticals and generic drug submissions reviewed on time	94% of pharmaceutical and generic drug submissions reviewed on time according to approved service standards, exceeding target of 90%.
Percentage of biologic drug submissions reviewed on time	100% reviewed on time, exceeding target of 90%.
Percentage of pre-market submissions backlog reduced for: - veterinary drugs - natural health products	92% of backlogged veterinary drug submissions in workload as of April 1, 2007 completed, exceeding target of 70%. 55% of natural health product Product License Applications completed, leading to regulatory decisions. No targets set.

Health Risk/Outcome Area: Safe food	
Performance Indicators	**Results**
Percentage of pre-market submissions backlog reduced	93.5% of 31 oldest food submissions (phase I of backlog reduction: non-regulatory submissions) processed.

Health Risk/Outcome Area: Access to information to make informed decisions	
Performance Indicators	**Results**
Level of satisfaction of Canadians and health professionals with the information disseminated for healthy choices and informed decision-making	83% responded that we did an excellent job of communicating information in both official languages. 66% responded that we offer sufficient options for receiving information. 64% responded that we provide information in a timely fashion.
Number of information products disseminated related to health products and food	Over 1,480 CD ROMS distributed, providing access to information about health products and the food regulatory system. Website used for education campaign on poultry safety. Guide on nutrition labelling and claims posted on website. Human Health Risk Assessment of Mercury in Fish and Health Benefits of Fish Consumption posted on website. Social marketing campaign, including television ads, encouraged Canadians to use Nutrition Facts tables on food packages to make informed food choices.
Number of revised copies of *Canada's Food Guide* disseminated	Over 13 million copies of the revised *Canada's Food Guide* disseminated. Over 250,000 resource guides for educators and communicators distributed.
Percentage of target population reached	70%
Number and nature of tools and approaches implemented to better integrate transparency and openness into HPFB's daily business	Over 3,000 copies produced of the Policy on Public Input in the Review of Regulated Products, related guidance and associated tools and templates. Held over 150 consultations on a range of topics. Held almost 100 meetings for external advice and input. Evaluation reports posted on the Health Canada website.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
257.4	316.5	307.9

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
2,668	2,623	45

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:

- Funding from Management Reserve - Natural Health Products
- Funding for Phase II of Bovine Spongiform Encephalopathy
- Funding for Therapeutics Access Strategy
- Funding for Collective Agreements

Variances between total authorities and actual spending are mainly due to:

- Lapse of frozen allotment for Access to Medicines Regime
- Other operating lapses in various programs

Health Canada is responsible for the regulation of health products and food. Our objective is to evaluate and monitor the safety, quality and effectiveness of the thousands of drugs, vaccines, medical devices, natural health products and other therapeutic products available to Canadians, as well as the nutritional quality of food. We review veterinary drugs sold in Canada for safety and effectiveness for animals and for safety of foods derived from animals treated with these drugs. We promote the health and well-being of Canadians by developing nutritional policies and standards such as *Canada's Food Guide* and by providing information to the public in newsletters such as *It's Your Health*.[23]

The *Report on Plans and Priorities* emphasized our commitment to modernize the Department's legislative and regulatory frameworks to keep pace with the rapid evolution of science and technology, existing and emerging public health challenges, consumer expectations in terms of safety, the need for transparency, international developments and other factors. We committed to do so through continued action under the Therapeutics Access Strategy, which began in 2003-2004, as well as work under the Blueprint for Renewal II[24] and 2007-2012 Health Products and Food Strategic Plan,[25] which were published in April 2007 following extensive consultations with stakeholders.

Those efforts laid the groundwork for a prompt response by the Government to well-publicized incidents raising concerns about the safety of some health and consumer products in 2007. It enabled our Department to support the Government quickly in developing the Food and Consumer Safety Action Plan,[26] which the Prime Minister announced in December 2007 and in preparing for the new funding for Action Plan initiatives announced in Budget 2008. We also supported the process to draft legislation for introduction in Parliament in April 2008 to modernize the *Food and Drugs Act*.[27]

The results of these efforts and new authorities set out in the legislation tabled in Parliament will bring about new measures to strengthen health and safety systems. We will be able to regulate health products throughout their life cycles and we expect to put in place better tools to identify and act on food safety risks. We will gain new authorities for compliance and enforcement, such as the power to order health product recalls as needed.[28]

At the same time as work related to the Action Plan took place, we advanced other elements of the Blueprint and Strategic Plan, such as consultations on user fee proposals for human drugs and medical devices, as well as the coming into force of the Safety of Human Cells, Tissues and

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[23] http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/index-eng.php

[24] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/blueprint-plan/blueprint-plan_II-eng.php

[25] http://www.hc-sc.gc.ca/ahc-asc/pubs/hpfb-dgpsa/strat-plan-2007-2012-eng.php

[26] http://healthycanadians.ca/pr-rp/action-plan_e.html

[27] http://www.parl.gc.ca/common/bills_ls.asp?lang=E&ls=c51&source=library_prb&Parl=39&Ses=2

[28] http://www.hc-sc.gc.ca/dhp-mps/homologation-licensing/index-eng.php

Organs for Transplantation Regulations. The Action Plan, Budget 2008 resources and user fee proposals will help Health Canada address the recommendations of the Auditor General in her November 2006 report on the allocation of resources to regulatory programs.[29]

Under the Health Products and Food Program Activity there are four sub-activities. Achievements under each of the sub-activities are outlined below.

Pre-market Regulatory Evaluation and Process Improvement

Description: A modernized regulatory system: making regulatory functions more efficient, effective, flexible and responsible to Canadians by streamlining processes and collaborating more closely with other organizations to ensure Canada continues to have a world class regulatory environment.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
123.3	151.6	147.5

Expected Results: Timely product assessment for health products and food	
Performance Indicators	**Results**
Percentage of decisions made within performance targets by type for submissions related to: - pharmaceuticals - medical devices - biologics	94% of new pharmaceuticals and generic drug submissions reviewed on time (target - 90%). 73% of Class II, III, IV medical device applications reviewed on time (target - 90%). 100% of biologic drug submissions reviewed on time (target - 90%).
Percentage of pre-market submissions backlog reduced for: - veterinary drugs - natural health products - food	92% of backlogged veterinary drug submissions in workload as of April 1, 2007 were completed (exceeding target of 70%). 93.5% of 31 oldest food submissions were processed. 55% of the natural health product Product License Applications were completed.
Expected Results: A modern regulatory system for health products and food that meets the needs of Canadians	
Percentage of Blueprint for Renewal initiatives completed on schedule	Significant progress was made on Blueprint for Renewal initiatives.

[29] OAG report:http://www.oagvg.gc.ca/domino/reports.nsf/html/20061108ce.html

Continue to improve the efficiency of the regulatory process

Using funding received in Budget 2003 under the Therapeutics Access Strategy, a five-year, $190 million initiative, we continued to reduce submission backlogs and meet international review standards for new pharmaceutical and biologic drug submissions. As the table above indicates, the new funding has enabled us to improve the timeliness of our regulatory decision-making and significantly reduce backlogs of applications awaiting decisions. We are now exceeding our service standard targets in most areas and, for example, are well-positioned to eliminate veterinary drug submission backlogs by the end of 2008-2009. We have completed phase 1 of our backlog reduction strategy for food submissions and created the new Standard Operating Procedures and workflow management tools to support in success in phase 2.

There were two notable exceptions to that progress trend during the year. One was for certain classes of medical devices, where timeliness was affected by the increased number and complexity of submissions. The other was for the rapidly growing field of natural health products. In response, we prioritized the submissions that we received to enable the processing of a greater number of applications in accordance with Natural Health Product Regulations.

We made progress on a more efficient regulatory process through a revised Cost Recovery Framework updating a 10-year-old fee regime.[30] This Framework sets fees and service standards for regulation, licensing, and post-market surveillance of health products. A key step in 2007 was our posting of the Official Notice of Fee Proposal for Human Drugs and Medical Devices, which enabled stakeholder feedback and led to finalization of the Framework.

Modernizing our Regulatory Framework

The introduction to this Strategic Outcome described the overall process of regulatory renewal that has been taking place under the Blueprint for Renewal, the Action Plan and the proposed amendments to the *Food and Drugs Act*. While these are expected to lead to a framework with enhanced tools available for Health Canada to protect and promote the health and safety of the public, work is under way to modernize, where possible, regulatory frameworks under the existing *Food and Drugs Act* to address existing issues. Many were identified as commitments in the *Report on Plans and Priorities*.

Our Department started to implement the new regulatory framework for cells, tissues and organs, and began posting proposed regulations in *Canada Gazette Part II* in December 2007.[31] We also continued to emphasize the value of making clinical trial information publicly accessible in registries, which enables patients, physicians, researchers and other interested stakeholders, to make more informed choices. As an immediate step, we encouraged registration of clinical trials[32] under the existing voluntary regime, while exploring a regulatory amendment to make registration mandatory.

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[30] http://www.hc-sc.gc.ca/dhp-mps/finance/costs-couts/consultation/activit/off_notice-eng.php
http://www.hc-sc.gc.ca/dhp-mps/consultation/cri-irc/index-eng.php
http://www.hc-sc.gc.ca/dhp-mps/finance/costs-couts/consultation/result/report_rapport-eng.php

[31] http://www.hc-sc.gc.ca/dhp-mps/compli-conform/info-prod/cell/index-eng.php

[32] http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/proj/enreg-clini-info/index_e.html

In October 2007, the Department published a consultation document, Management of Pre-Market Submissions for food submissions,[33] describing the proposed process for interacting with applicants during the pre-market submission review process. A separate discussion paper, Managing Health Claims for Foods in Canada: Towards a Modernized Framework,[34] was released to support consultations. The scope of that consultation was expanded to include front-of-package labelling, reflecting points made by the Standing Committee of the House of Commons on Health, as well as claims on food-like natural health products.

In May 2007, we completed an on-line Natural Health Products Regulatory Review to guide our choices in this growing area of interest for Canadians. The comments received have aided in preparation of new policy approaches including a new risk-based approach to regulating these products. We intend to clear the backlog of pre-market reviews by streamlining reviews of lower-risk products and focusing our resources on products that pose higher risk.

The decision to move forward rapidly to support development of the Action Plan and other efforts to accelerate modernization of our regulatory system led us to delay to 2008-2009 some regulatory initiatives that we described in the *Report on Plans and Priorities*. Those issues included: regulations enabling access to unauthorized drugs for mass distribution for either an immediate emergency or in anticipation of a health emergency; revised Nutrition Labelling Regulations; a new regulatory framework for vaccines; regulatory amendments for addition of vitamins and minerals to foods; and, publication of a new regulatory framework for blood.[35]

International Regulatory Cooperation

Canada and other countries are pursuing cooperative agreements and actions to gain efficiencies and improve information availability. Consistent with this commitment, the Memorandum of Understanding (MOU) between Health Canada and the U.S. Food and Drug Administration (FDA) was broadened to include sharing of information about food and natural health products. A new MOU with the Therapeutic Goods Administration (TGA) of Australia was signed regarding quality management system certification for medical devices.

Our Department signed an MOU relating to substances for pharmaceutical use with the European Directorate for the Quality of Medicines and HealthCare (EDQM). As well, a new confidentiality arrangement with the European Commission (EC) and the European Medicines Agency (EMEA) allows for sharing of information relating to therapeutic products (pharmaceuticals, radiopharmaceuticals, biologics and natural health products) for human and veterinary use.

[33] http://www.hc-sc.gc.ca/fn-an/consultation/blueprint_food-plan_aliments/pre_mark_sub-dem_pre-eng.php#m
[34] http://www.hc-sc.gc.ca/fn-an/consultation/init/man-gest_health_claims-allegations_sante-eng.php
[35] http://www.hc-sc.gc.ca/dhp-mps/acces/sap_pas_comp_e.html

Information, Education and Outreach on Health Products, Food and Nutrition

Description: Responding to increased consumer interest in health issues by disseminating more information, and improving access to information that enables consumers to make appropriate decisions about health products and food safety, and nutrition.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
9.5	11.7	11.4

Expected Results: Public and stakeholders are aware of and have access to information that enables them to make informed decisions regarding the safety of health products, food and nutrition	
Performance Indicators	**Results**
Number of information products disseminated related to: - drugs and health products - food - nutrition	Over 1,480 CD ROMS distributed, providing access to information about health products and the food regulatory system. Over 13 million copies of the revised *Canada's Food Guide* disseminated. Over 250,000 resource guides for educators and communicators distributed (*Canada's Food Guide*).
Percentage of target population reached	70%
Level of satisfaction of public and health professionals with the information disseminated for healthy choices and informed decision-making	83% responded that we did an excellent job of communicating information in both official languages. 66% responded that we offer sufficient options for receiving information. 64% responded that we provide information in a timely fashion.

Our commitment to information, education and outreach took many forms. We began implementing a five-year Consumer Information Strategy, a commitment in the Blueprint for Renewal II to produce consumer-friendly information on health products and food and the regulatory system. Under the Strategy, we developed new products to improve usability and accessibility to departmental information; produced Branch reports in plain language; and, engaged patient and consumer stakeholders in three regions in a pilot education project on reporting side effects of drugs, which generated valuable feedback on how to improve reporting.

One of our best-known products is *Canada's Food Guide*,[36] with over 13 million copies of the revised edition disseminated between the launch in February 2007 and March 31, 2008. We also distributed over 250,000 resource guides for educators and communicators and recorded 3.5 million visits to our Food Guide homepage. To meet the needs of an increasingly diverse

[36] http://www.healthcanada.gc.ca/foodguide

population, we launched the first national Food Guide for Aboriginal People, *Eating Well with Canada's Food Guide - First Nations, Inuit and Métis* in April 2007. After research to determine what information, tools or processes could assist new immigrants in making healthy food choices, we translated *Canada's Food Guide* into Arabic, Chinese, Korean, Farsi, Punjabi, Russian, Spanish, Tagalog, Tamil and Urdu.

Nutrition labelling became mandatory for all prepackaged foods in December 2007. In January 2008, we launched a social marketing campaign to encourage Canadians to use the Nutrition Facts table on food products to make informed choices as they compare products. This included a 30-second television advertisement in English and French that aired from January to March 2008. The campaign also included Internet banner advertisements, a newspaper insert and a supermarket tear sheet featured in over 3,000 grocery stores. We also improved our nutrition labelling website to make information more accessible.[37]

Our Department carried out a wide range of other education, information and outreach efforts. One example is our launch of an on-line education campaign on poultry safety in June 2007. Others are our posting of *A Guide to Developing Accurate Nutrient Values* on nutrition labelling and claims as well as a *Human Health Risk Assessment of Mercury in Fish* and *Health Benefits of Fish Consumption* on our website. A consultation report on unpasteurized juice was finalized and several food allergy incidents management workshops were held with stakeholders, including industry and major food allergy consumer groups.[38]

Risk communications is increasingly important. Our MedEffect Canada website continued to provide access to our latest advisories, warnings and recalls concerning marketed therapeutic drugs, natural health products and medical devices. The 20 percent increase in subscribers to MedEffect e-Notice shows the interest in this information.[39]

Some of our actions add to detailed knowledge of food issues. We released a report on the Canadian Community Health Survey Cycle 2.2, Nutrition (2004): *Income-Related Household Food Security in Canada* that includes estimates of income-related food security status at the household, adult and child levels. It also describes a new approach to interpreting food security data, and results on the food security status of Aboriginal people off-reserve.[40]

An element of commitments under this activity was to address emerging health issues. As part of this, we completed a Teacher's Kit on Biotechnology based on needs expressed by high school teachers and education specialists we consulted. We also continued to lead an

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[37] http://www.healthcanada.gc.ca/nutritionlabelling

[38] http://www.hc-sc.gc.ca/fn-an/label-etiquet/allergen/index_e.html
http://www.hc-sc.gc.ca/fn-an/label-etiquet/meat-viande/index_e.html
http://www.hc-sc.gc.ca/fn-an/securit/facts-faits/unpast_fruit_juices-jus_fruits_cidre_nonpast_e.html
http://www.hc-sc.gc.ca/fn-an/securit/handl-manipul/fbac-abac/index_e.html
http://www.hc-sc.gc.ca/fn-an/pubs/mercur/merc_fish_poisson_e.html
http://www.hc-sc.gc.ca/fn-an/securit/allerg/fa-aa/index_e.html
http://www.hc-sc.gc.ca/fn-an/securit/allerg/cel-coe/index_e.html

[39] http://www.hc-sc.gc.ca/dhp-mps/medeff/index-eng.php

[40] http://www.hc-sc.gc.ca/fn-an/surveill/

interdepartmental initiative to develop and implement a 21st century "stewardship" approach to regulatory decision-making that takes a comprehensive view on products of new technologies.[41]

Monitoring Safety and Therapeutic Effectiveness and Risk Management

Description: Increasing responsiveness to specific public health issues and the ability to manage risks through development of sustainable research, monitoring and surveillance systems and stronger compliance and enforcement activities. Increased ability to manage risks associated with the food supply, including food safety emergencies, in order to provide safer food to Canadians.

Expected Results: Strengthened safety of health products available to Canadians	
Performance Indicators	**Results**
Compliance with the *Food and Drugs Act* and its regulations	42 advisories, warnings and recalls for drugs and health products disseminated to health professionals.
Number of advisories, warnings and recalls for drugs and health products posted on the Health Canada website for the public and health professionals	124 advisories, warnings and recalls for drugs and health products disseminated to the public. 21 advisories, warnings and recalls for food and nutrition disseminated to the public.
Expected Results: Compliance with the *Food and Drugs Act* and its regulations	
Percentage annual increase in adverse reaction reports received	Increase over the previous year of 22%.
Number of inspections	Over 900 inspections were conducted, including 210 Medical Device Establishments
Percentage of compliance based on total number of inspections (of establishments) completed	98% compliance.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
110.4	135.8	132.1

Consistent with our commitment to research and surveillance in the *Report on Plans and Priorities*, we undertook a variety of activities to identify human health risks. An example was our risk assessment and development of risk management strategies for use of Bisphenol A in food packaging. This has led to work to classify Bisphenol A in the list of Substances on Schedule 1 of the *Canadian Environmental Protection Act*. We also delivered on food-related assessments for priority substances listed under the Chemicals Management Plan and practised,

[41] http://www.hc-sc.gc.ca/sr-sr/biotech/index_e.html / http://www.bioportal.gc.ca/english/BioPortalHome.asp

improved and formalized a protocol for emergency preparedness and response related to avian influenza.

Our Medical Device Establishment inspection program conducted 210 inspections, exceeding the target of 205. While we had set a target of 85 inspections of clinical trials for Good Clinical Practice (GCP), reflecting the two percent international benchmark for annual inspections, we were only able to conduct 33 GCP inspections. We were hampered by staffing delays and the lengthy training that these specialized inspectors require.

Health Canada's Atlantic Region co-chaired the Nova Scotia Food and Health Products Safety Network with the Nova Scotia Department of Agriculture and Fisheries. The Network worked to improve and put into practice an avian influenza emergency preparedness and response protocol; to clarify roles, responsibilities and jurisdictional issues for food and product safety activities and emergencies; and, to exchange information to harmonize regulatory initiatives.

We completed market surveys of two unapproved claims relating to cancer and depression. These led to potentially harmful health products being recalled from the retail market and unapproved claims removed from websites and print advertising. More generally, we moved forward on the Compliance and Enforcement Strategy in the Blueprint for Renewal and solicited the views of industry associations on compliance and enforcement and communication with Health Canada. The Department conducted an industry sector scan to determine what increases or motivates compliance of specific regulated sectors.

We completed a three-year project to develop and implement the Canada Vigilance System, increasing capacity for adverse reaction information management and data mining. Our tracking of adverse reactions to drugs and other therapeutic products generated 22 percent greater volumes than in 2006-2007. An external Expert Advisory Committee on the Vigilance of Health Products was established to provide research and advice on post-market surveillance priority issues.

Transparency, Public Accountability and Stakeholder Relationships

Description: Bringing more transparency to our decision-making processes by providing more accessible information about the evidence, processes and rationale underpinning our decisions. Health Canada is also strengthening its capacity to involve the public more meaningfully and inclusively in regulatory decision-making.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
14.2	17.4	16.9

Expected Results: Transparency, accountability and openness are integrated into Health Canada's daily business	
Performance Indicators	**Results**
Number and nature of tools and approaches implemented to better integrate transparency and openness into HPFB's daily business	Over 3,000 copies of the HPFB Policy on Public Input in the Review of Regulated Products, the related guidance and associated tools and templates were produced.

As part of the Policy on Public Input in the Review of Regulated Products and related guidance that was made public in May 2007, we developed tools and templates that enable public involvement in the day-to-day business of developing policy and programs, as well as our review of regulated products.

As indicated previously under this Strategic Outcome, the engagement of health professionals, academics, patients, consumers, industry and other stakeholders was a central feature in developing and moving forward on the Blueprint for Renewal II and the Food and Consumer Safety Action Plan. In particular we:

- Held over 150 consultations, including for the Cost Recovery Regime, Health Claims for Food, the Product Life Cycle Approach, and review of the Special Access Program. These consultations had impacts such as the postponement of a cost recovery framework for natural health products;
- Held 51 bilateral meetings and 42 advisory committee meetings to gather advice and input from external advisors.

We posted approximately 1,500 Product Monographs on the Health Canada website. These factual, scientific documents on drug products describe the properties, claims, indications, and conditions of use as well as other information that may be required for optimal, safe, and effective use. While most monographs are only available in English, we have put procedures in place to request French language versions from the sponsors once the monographs have been finalized and authorized.[42]

Our Summary Basis of Decision (SBD) project was created to enhance the transparency of our drug and medical device regulatory review process. Each SBD outlines the scientific and benefit/risk-based factors in Health Canada's decision to grant market authorization for a drug or medical device. Under this project, we published 20 Notice of Decisions (NDs) and 11 SBDs for pharmaceutical human drugs; four NDs and 12 SBDs for biologics and seven NDs and five SBDs for medical devices.[43]

The Department's commitment to transparency included posting evaluation reports for the following initiatives:

[42] http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/proj/monograph-rev/index_e.html

[43] http://www.hc-sc.gc.ca/dhp-mps/prodpharma/sbd-smd/index-eng.php

- Augmenting Health Canada's Response to Bovine Spongiform Encephalopathy (BSE I) and Further Measures on BSE in the Areas of Risk Assessment and Targeted Research (BSE II)
- Canada's Access to Medicines Regime (CAMR)
- Genomics Research and Development Initiative
- Canadian Regulatory System for Biotechnology (CRSB)
- Natural Health Products Research Program

We have completed most actions taken as a result of the recommendations in these evaluations with the remainder to come during 2008-2009. For example, the evaluation of the Natural Health Products Research Program taught us that we need to increase our communication, collaboration, coordination efforts and knowledge transfer with international partners, regulatory and academic entities, NHP practitioners, industry and consumers.

STRATEGIC OUTCOME #3a:

Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments

Program Activity Name:
Healthy Environments and Consumer Safety

Expected Results:

- Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances
- Reduced risks to health and safety, and improved protection against harm associated with workplace and environmental hazards and consumer products (including cosmetics)

Health Risk/Outcome Area: Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances	
Performance Indicators	**Results**
Substance use and abuse	
Reduce smoking prevalence in Canada from 19% in 2001 to 12% in 2011	Just under five million Canadians, representing 19% of the population aged 15 years and older, were smokers in 2007. Canada's smoking rate (19%) is lower than in the UK (25%), Australia (19.8%) and France (27.0%). The smoking rate in the U.S. is 17.5%.
Decrease in health-related, at-risk behaviours associated with substance use within the general population, and specifically, youth and Aboriginal persons	Provided over $6.5 million in national and regional funding for 65 community-based initiatives to prevent and/or diminish substance use/abuse. 43 clandestine laboratories were investigated and 19 dismantled. Disrupted production of 1,055,000 variegated multiple doses of meth/ecstasy/GHB (630,000 of methamphetamine, 145,000 of MDMA and 280,000 of GHB).
Health Risk/Outcome Area: Reduced risks to health and safety, and improved protection against harm associated with workplace and environmental hazards and consumer products (including cosmetics)	
Performance Indicators	**Results**
Toxic substances/product safety	
Rate of industry compliance with regulations	80% compliance rate for products inspected of targeted products expected to be non-compliant.
Workplace health and public safety	
Rate of industry compliance with regulations	Water Management Plans were implemented with nine major Canadian airline carriers, representing 80% of the industry.

Timely and appropriate psycho-social advice, guidance and professional services to federal employees Timely response to radiation exposure data for workers	Employee Assistance Services helped clients achieve problem resolution within its short-term counselling model in 92% of cases. Provided timely, responsive and reliable customer services to 95,000 workers in 12,700 groups.
Performance Indicators	**Results**
Environmental health	
Level of understanding of environmental health risks: percentage of Canadians who are knowledgeable about environmental impacts on their health	Environmental health monitoring and surveillance under the Canadian Health Measures Survey and the Northern Contaminants Program is under way. Environmental health indicators are being developed. Air Quality Health Indicator launched, beginning in British Columbia and Toronto. New legislation related to Canada's Food and Consumer Safety Action Plan was tabled in Parliament in April 2008. Plans for improvement and expansion of the Chemicals Management Plan (CMP) portal/website have been developed, including documents to translate scientific information for a non-technical audience. Progress on the re-evaluation of older pesticide active ingredients: as of March 31, 2008, 274 of the 401 active ingredients had been re-evaluated Established a horizontal science framework to manage research funds collectively and align annually to CMP priority research. A Challenge Advisory Panel (experts) and CMP Stakeholder Advisory Council (NGOs/industry) established.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
333.8	357.0	334.4

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
2,074	2,141	67

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:

- Funding for the National Anti-Drug Strategy
- Funding from Management Reserve - Public Service Health Program
- Funding for Collective Agreements

Variances between total authorities and actual spending are mainly due to:

- Implementation of the Clean Air Regulatory Agenda reprofile
- Drug Strategy and Community Initiatives Fund reprofile
- Other lapses in various programs

Health Canada is responsible for assessing and acting on many elements of day-to-day living that have impacts on the health of Canadians. These include drinking water safety, air quality, radiation exposure, substance use and abuse (including alcohol), consumer product safety, tobacco and second-hand smoke, workplace health, and chemicals in the workplace and in the environment. We are also engaged in chemical and nuclear emergency preparedness; inspection of food and potable water for the travelling public; and health contingency planning for visiting dignitaries. This year, many of our activities responded directly to priorities outlined in the Speech from the Throne, particularly in connection with healthy environments and a safe and secure Canada. The Department has been addressing these priorities through: compliance and regulations; standards and guidelines; increased awareness of regulated health products; enhanced involvement of stakeholders; and scientific knowledge and capacity to support decision-making. Demonstrable progress was made in a number of key areas:

- **Canada's Food and Consumer Safety Action Plan** introduced a portfolio-wide approach to enhancing the safety system for food, health and consumer products.

- In partnership with Environment Canada, we moved forward on the **Chemicals Management Plan (CMP) and the Clean Air Agenda (CAA)**. These initiatives protect Canadians from hazardous chemicals and pollutants as part of the Government's Environmental Agenda.

- The Department continued to reduce the harmful consequences associated with substance use/abuse through prevention, treatment and enforcement activities, as well as administering the *Controlled Drugs and Substances Act*. Health Canada is part of the Government's **National Anti-Drug Strategy**[44] announced in October 2007 and leads the development of the prevention and treatment components.

- Our Department leads the **Federal Tobacco Control Strategy (FTCS).** Evaluation of the first five years of the 10-year FTCS found that many objectives had been achieved. Health Canada identified new goals for 2007-2011 to further reduce smoking prevalence through relationships between federal, provincial and territorial governments and NGOs.

As part of Health Canada's response to the Office of the Auditor General's (OAG) 2006 report, Allocating Funds to Regulatory Programs, Health Canada reviewed all regulatory programs and activities, including those covered under this program activity. We established multi-year management action plans to address issues requiring additional investigation or remediation. The comprehensive reviews confirmed the need to increase capacity for management excellence,

[44] http://www.nationalantidrugstrategy.gc.ca/

including integration of performance information into resource allocation decisions. Activities are now supported by both an integrated planning and reporting framework as well as a new performance measurement framework. Both frameworks will enable improved planning, stewardship of resources, monitoring and reporting.

High demand and competition for scientific and public health professionals has posed a recruitment challenge. As a result, we developed a multi-year people management plan and launched collective staffing processes to improve our recruitment processes.

We have fulfilled our responsibilities in accordance with sustainable development principles. Building on the success of Health Canada's Sustainable Development Strategy (SDS) III, the Department developed a fourth SDS for 2007-2010. Our Strategy reflects an approach that will enable government-wide reporting on issues such as clean air, clean water, sustainable communities and protection of the environment and human health.

Safe Environments

Health Canada conducts research, risk assessments and management, monitoring, and surveillance to protect Canadians from risks associated with chemical substances, drinking water, air quality, contaminated sites, climate change, as well as preparedness for environmental emergencies.[45] These respond to the Department's obligations under the *Canadian Environmental Protection Act* (CEPA) 1999.[46]

Expected Results: Reduce, eliminate, prevent, or better manage toxic chemical substances and their use and/or exposure	
Performance Indicators	**Results**
Establishment and maintenance of a monitoring and surveillance program to track public health and environmental priorities (for use in future years to track performance)	Environmental heath monitoring and surveillance under the Canadian Health Measures Survey and the Northern Contaminants Program is under way. Environmental health indicators are being developed.
Expected Results: Increase knowledge, understanding and involvement by Canadians in environmental health issues	
Survey results on Canadians' knowledge, understanding and involvement in environmental health issues Percentage of Canadians who are more knowledgeable about how the environment impacts their health e.g. sun exposure	Baselines being developed; surveys being initiated. Air Quality Health Indicator launched, beginning in British Columbia and Toronto.
Expected Results: Improve scientific knowledge and capacity on environmental health issues	
Increase in the number and types of publications authored by Health Canada and published in peer-reviewed scientific journals	Baselines being developed. Information being gathered on uptake of published scientific documents (i.e. number of publications being used by the scientific community).

[45] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/sep-psm/index-eng.php

[46] http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/environ/cepa-lcpe-eng.php

Extent to which risk assessment methodologies are harmonized with other countries	Published scientific documents on Chemicals Management Plan (CMP) website and summaries in *Canada Gazette*. Participated in international meetings/workshops and Canada-U.S.-Mexico activities.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
131.1	122.1	114.0

Health Canada and Environment Canada collaborated to advance the Chemicals Management Plan (CMP)[47] and the Clean Air Agenda (CAA) as part of the Government's Environmental Agenda.

The CMP is linked to legislation such as the *Canadian Environmental Protection Act*,[48] the *Food and Drugs Act*, *Hazardous Products Act* and the *Pest Control Products Act*. In addition to increasing health and environmental research, monitoring and tracking, the CMP provides an opportunity for industry and other stakeholders to input into the decision-making process. The CMP places the onus on industry to supply the Government with information about how they are safely managing high priority chemical substances.

As part of the CMP "Challenge" initiative, 200 substances of highest priority were identified, leading to assessments and risk management approaches for substances such as Bisphenol A in baby bottles.

The Domestic Substances List (DSL) is a list of 23,000 substances. When a proposed activity or use of a substance is different from the one identified in its original notification, a Significant New Activity (SNAc) can be placed on a substance. The implementation of SNAcs for approximately 56 substances no longer in commerce in Canada began. We also completed a work plan to deal with petroleum stream substances.

Health Canada advanced Clean Air Agenda elements, such as assessment of health risks from emissions from indoor and outdoor air pollution sources, including fuels and consumer and commercial products. The Department completed Indoor Air Quality Guidelines for ozone and carbon monoxide and developed and consulted on a priority list of indoor air contaminants as a basis for guidelines. Work on Indoor Air Quality Guidelines for particulate matter and nitrogen dioxide began. We also contributed to development of ambient air regulations as part of the Clean Air Regulatory Agenda. The Department continued to refine the Air Quality Benefits Assessment Tool (AQBAT), to estimate the health benefits or damages associated with changes in Canada's ambient air quality. Using AQBAT, we performed the initial health economic analysis and provided estimates of the benefits (physical and monetary) of proposed regulations to inform the Regulatory Framework for Air Emissions. Research for an Air Health Indicator (AHI) also continued.

[47] http://www.chemicalsubstanceschimiques.gc.ca/plan/index_e.html
[48] http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/environ/cepa-lcpe-eng.php

Also with Environment Canada, Health Canada launched the Air Quality Health Index (AQHI) to provide a daily measure of air pollution health impacts.[49] The Index provides the public with information to make decisions to reduce exposure to potentially harmful effects associated with air pollution. Implementation of the AQHI has taken place in Toronto and 14 communities in British Columbia and there are plans to expand to other Ontario cities and the Maritimes in the next year.

A summative evaluation assessed Health Canada's progress in achieving results under the Border Air Quality Strategy (BAQS) that ran from 2003-2004 to 2006-2007. The evaluation confirmed good value for money and recommended measures to strengthen delivery of similar future activities, including a formal tracking and reporting program with clear indicators.

Radon is a radioactive gas found naturally in the environment that can seep into buildings. Its ionizing radiation can cause cancer. To protect Canadians from potential dangers of radon gas, the Department implemented a National Radon Strategy and a complementary work plan was developed and approved by the Federal/Provincial/Territorial Radiation Protection Committee. We completed guidelines and held 15 workshops across Canada to reach home inspectors and other professionals involved in radon testing of homes and large buildings. The Department developed maps to identify radon-rich areas that will receive additional focus during the upcoming public education and awareness campaign.[50]

Our Canadian Climate Change and Health Vulnerability Assessment identifies current and future vulnerabilities of Canadians and their communities to health risks associated with climate change. Our goal was to produce a tool that health professionals, scientists and decision-makers could use to determine the best ways to prepare for and adapt to these changes. Our Department also began to implement a climate change adaptation program and a heat alert and response system. A special *Your Health and a Changing Climate* Newsletter was issued as well, to raise awareness of climate change health risks.[51]

Health Canada worked with World Health Organization (WHO) networks to enhance the safety of drinking water in small communities. Five new Guidelines for Canadian Drinking Water Quality were completed. The Department, in collaboration with the Public Health Agency of Canada, completed a real-time alert system for Drinking Water Advisories to improve inter-jurisdictional coordination of responses to water-borne threats to health. Federal departments adopted a Federal Water-Borne Contamination and Illness Response Protocol and use the real-time alert system. This system will improve surveillance and understanding of the root causes of Drinking Water Advisories.[52]

[49] http://www.hc-sc.gc.ca/ewh-semt/air/index-eng.php
[50] http://www.hc-sc.gc.ca/ewh-semt/radiation/radon/index-eng.php
[51] http://www.hc-sc.gc.ca/ewh-semt/climat/index-eng.php
[52] http://www.hc-sc.gc.ca/ewh-semt/water-eau/index-eng.php

Product Safety

Canada's Food and Consumer Safety Action Plan, released in December 2007, is a portfolio-wide approach to enhancing the safety system for food, health and consumer products, recognizing that safety is a shared responsibility among industry, consumers and government. The Action Plan rests on three pillars: prevention of incidents, enhancing targeted oversight by government and rapid response in identifying and addressing risks. A major component is the proposed Canada Consumer Product Safety Act to update the consumer product safety regime including modernization of the *Radiation Emitting Devices Act*, and the Cosmetic Regulations under the *Food and Drugs Act*.

Under the *Hazardous Products Act* and the *Radiation Emitting Devices Act*, Health Canada identifies, assesses, manages, and communicates to Canadians health and safety hazards associated with: consumer products; hazardous workplace materials; cosmetics; new chemical substances; products of biotechnology; radiation produced by radiation-emitting devices; environmental noise; and solar UV radiation.

Expected Results: Reduce risk of death, illness, and injury from exposure to hazardous products and substances associated with: consumer products; cosmetics; workplace chemicals; new chemical substances; products of biotechnology; radiation-emitting devices; environmental noise; and solar UV radiation	
Performance Indicators	**Results**
Increased industry rate of compliance with regulations	New legislation related to Canada's Food and Consumer Safety Action Plan was tabled in Parliament in April 2008. Industry compliance results are to become available in 2008-2009.
Increased public awareness of risks	Subscriptions to the Consumer Product Safety Recall website increased from 800 to 5,000.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
31.2	39.2	36.6

As part of a Food and Consumer Safety Action Plan, the Prime Minister announced the Government's intention to introduce legislation. This flowed from the Speech from the Throne, in which the Government announced that it would take action by "introducing measures on food and product safety to ensure that families have confidence in the quality and safety of what they buy." We supported the drafting of the proposed legislation which was introduced in Parliament in April 2008.

In response to the large number of toy recalls in 2007 in Canada, and internationally, due to excess lead in painted coatings, we launched an extensive toy and children's items sampling and testing project in 2007 and also checked lead levels in children's jewellery.[53] Based on targeted expected rate of non-compliance, more than 80 percent of products inspected were in compliance with our standards and we took enforcement action on non-complying products.[54]

The Minister of Health launched our new Consumer Product Safety Recall website[55] in October 2007. This gave Canadians a centralized, easily searchable location to find information, including pictures, on consumer products recalled in Canada.

Since many products on sale in Canada are produced in China, an updated Memorandum of Understanding (MOU) was signed with the People's Republic of China - General Administration for Quality Supervision, Inspection and Quarantine (AQSIQ) in November 2007. The MOU allows for increased information-sharing, ensuring that Chinese manufacturers understand Canadian requirements; implementation of an emergency response mechanism; and improved safety of imported products. Three technical working groups have been formed on toys and children's jewellery, textiles and lighters.

Health Canada continued to collaborate with various sectors in Canada and with our trading partners to implement the Globally Harmonized System of Classification and Labelling of Chemicals (GHS).[56] We conducted technical consultations and worked on the legislative and regulatory changes necessary for domestic GHS implementation that includes harmonization to the greatest extent possible between sectors in Canada and among the North American Free Trade Agreement (NAFTA) countries. Our Department completed risk assessments for 478 new chemicals and polymers, 156 transitional substances, three micro-organisms, and 32 U.S. Food and Drug Administration substances.

As part of the Chemicals Management Plan, Health Canada is assessing and, when appropriate, managing environmental exposure to new substances contained in *Food and Drugs Act* products e.g. pharmaceuticals, personal care products, cosmetics. Consultations took place with stakeholders (industry, consumer groups and environmental NGOs) to develop more appropriate regulations. We are also designing a nomination process for revision of the In Commerce List (approximately 9,000 substances in products regulated under the *Food and Drugs Act* that entered commerce in Canada between 1987 and 2001), as well as an approach for prioritization of substances for immediate assessment.

[53] http://www.hc-sc.gc.ca/cps-spc/pubs/cons/lead-plomb/index-eng.php
[54] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/psp-psp/index-eng.php
[55] http://www.hc-sc.gc.ca/cps-spc/advisories-avis/index-eng.php
[56] http://www.hc-sc.gc.ca/ahc-asc/intactiv/ghs-sgh/index-eng.php

Workplace Health and Public Safety

Expected Results: Timely and appropriate occupational health advice, guidance, and professional services to federal employees	
Performance Indicators	**Results**
Increase in number of service requests received and completed within service standards or carried over, according to Activity Tracking System (target: less than 20% carried over)	Program is undergoing transformation at this time. Indicators will be revised depending on final transformation decision; results to be available in 2009-2010.
Expected Results: Timely and appropriate psycho-social advice, guidance and professional services to federal employees	
Increase in rate of resolution of client problems within service standards (target: 80%)	Employee Assistance Services (EAS) helped clients achieve problem resolution within its short-term counselling model in 92% of cases. Other quality assurance measures all indicate satisfaction rates that meet or surpass this indicator.
Expected Results: Timely and appropriate public health interventions related to conveyances and ancillary services	
Increase in rate of implementation of water management plans within the Canadian airline industry (target: 80%) and rate of resolution of critical deficiencies (target: 90%) within service standards	Potable Water Management Plans were implemented with nine major Canadian airline carriers, representing 80% of the airline industry. The focus this year was on implementation; data to substantiate our success in resolving critical deficiencies will be available for next year's reporting cycle.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
31.1	48.8	48.4

Our Workplace Health and Public Safety Program (WHPSP)[57] provided occupational health services, advice and consultation, medical and workplace assessments, exposure prevention, control and management, as well as physical and psycho-social emergency preparedness and response for federal public servants. The Program protects the health of the travelling public by providing food, water and sanitation inspections on passenger conveyances and provides health services for visiting dignitaries. It coordinates cost-recovered Employee Assistance Program (EAP) services to more than one million Canadians in most of the public service, the military, RCMP, and retired DND and RCMP members and their families, with 90 percent of counselling services provided by a network of mental health professionals. We also delivered occupational health services nationally to federal departments and agencies on behalf of the Treasury Board Secretariat (TBS).

[57] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/whpsp-psstsp/index-eng.php

Health Canada's own Employee Assistance Services (EAS) is a full-service EAP provider, offering confidential, professional, 24/7 bilingual counselling services on a cost-recovery basis. Services include the Critical Incident Stress Management program that provided early identification and intervention for Health Canada nursing staff working in First Nations and Inuit communities. This employee group was identified as a high-risk population in terms of workplace injuries, including mental health issues resulting from exposure to violence and trauma.

Health Canada continued to protect the health of the over 85 million people per year who travel to, from and within Canada on conveyances such as aircraft, ships, and their ancillary services such as airports and flight kitchens. In June 2007, Health Canada was one of the first countries to issue Ship Sanitation Certificates in compliance with the International Health Regulations (IHRs) developed by the World Health Organization (WHO). These Certificates are issued as a control measure to ensure that ships meet public health requirements to reduce the introduction and spread of disease between countries. Health Canada's work with the airline industry has resulted in implementation of potable water management plans, improving the safety of water on 80 percent of Canadian-based carriers. In addition, we increased our capacity to respond to a public health emergency with a trained cadre of environmental health officers across the country.

Health Canada's International Health Program worked with all levels of government, the private sector and embassies to provide health services to Internationally Protected Persons (IPPs) and their family members while visiting Canada. This included events such as the North American Leaders' Summit in Montebello, Quebec.

Drug Strategy and Controlled Substances

Expected Results: Reduce health and safety risks associated with abuse of drugs, alcohol, and other controlled substances	
Performance Indicators	**Results**
Decrease in health-related, at-risk behaviours associated with substance use within the general population, and specifically, youth and Aboriginal persons	• Improved capacity to report on surveillance and monitoring activities. • Provided over $6.5 million for 65 community-based initiatives to prevent and/or diminish substance use/abuse. • 43 clandestine laboratories investigated and 19 labs dismantled with Drug Analysis Service assistance. • Disrupted production of 1,055,000 variegated multiple doses of meth/ecstasy/GHB (630,000 of methamphetamine, 145,000 of MDMA and 280,000 of GHB). • 14,812 licenses, import/export permits, authorizations and exemptions issued compared to 14,321 last year.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
76.6	84.8	80.2

As highlighted in Budget 2007, the National Anti-Drug Strategy involves the Department of Justice, Public Safety Canada and Health Canada and includes three action plans: preventing illicit drug use; treating those with illicit drug dependencies; and combating production and distribution of illicit drugs.[58] The refocused Drug Strategy Community Initiatives Fund and the new Drug Treatment Funding Program reflect our commitment to work with non-governmental organizations such as the Canadian Centre on Substance Abuse, and provinces/territories to address illicit drugs at the community level and encourage communities and stakeholders to initiate and invest in projects. The Strategy emphasizes the safe disruption of illicit drug operations by monitoring movement of precursor chemicals to prevent their diversion from the legal distribution chain.[59] Health Canada also contributes through Drug Analysis Service, training of law enforcement officers, aiding in the investigation of clandestine laboratories and authorizing destruction of seized controlled substances.

In 2007, we published a report, *Substance Use by Canadian Youth*, using 2004 Canadian Addictions Survey data. This study found that alcohol is the most commonly used substance with 90.8 percent of youth aged 15-24 reporting use in their lifetime and 82.9 percent reporting use in the past 12 months. Cannabis is the most commonly used illicit substance with 61.4 percent of youth having used cannabis in their lifetime. Almost one in 10 Canadian youth reported using marihuana on a daily basis.

Our Department completed questionnaire testing and development for the new Canadian Alcohol and Drug Use Monitoring Survey, which we will launch early in 2008-2009. Additionally, we completed the pilot phase of a monitoring system for drug seizure data in British Columbia. The data will provide regional, provincial and national estimates of the types and quantities of drugs seized and the dates and locations of the seizures.

Through the Drug Strategy Community Initiatives Fund (DSCIF),[60] Health Canada provided $2.9 million in funding for national projects and $3.7 million for regional projects. More than 65 health promotion and prevention projects and projects to reduce harms from substance use and abuse were supported, particularly those which targeted youth and professionals working in the field. To better understand and enhance impacts, a case study analysis was conducted on a random selection of 10 completed DSCIF projects. Positive outcomes included: increased awareness and knowledge of substance abuse issues, increased community involvement, increased number of networks and partnerships, and positive behaviour changes in individuals.

The Department continued to work on best practices by producing a document, *Early Intervention, Outreach and Community Linkages for Youth with Substance Use Problems*, as well as commissioning an uptake study on two best practices documents. The documents were well received with over 85 percent of respondents making use of them in: identifying training needs, planning or adopting practices, validating existing programs or identifying service gaps and providing justification to obtain funding.[61]

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[58] http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/index-eng.php
[59] http://www.hc-sc.gc.ca/dhp-mps/substancontrol/index-eng.php
[60] http://www.hc-sc.gc.ca/hl-vs/drug-drogues/dscif-ficsa/index-eng.php
[61] http://www.hc-sc.gc.ca/dhp-mps/substan/treat-trait/index-eng.php

Our Drug Analysis Service (DAS)[62] laboratories worked with law enforcement agencies to identify and analyze more than 107,000 exhibits, an increase of almost two percentage points from last year. We processed more than 113,000 requests for authorization to destroy seized controlled substances and 43 clandestine laboratories were investigated.

We developed performance measurement strategies for this area, including meaningful performance indicators.[63] Data will be collected and reported on in upcoming years, once the strategies are finalized and appropriate tools and systems developed.

Tobacco Control

Expected Results: Reduce smoking prevalence from 19% (2005) to 12% by 2011	
Performance Indicators	**Results**
Canadian Tobacco Use Monitoring Survey (CTUMS) (February-June 2007)	Slightly fewer than five million people, representing 19% of the population aged 15 years and older, were current smokers, of whom 15% reported smoking daily. These individuals reported smoking on average 15.3 cigarettes per day. CTUMS results for the first half of 2007 indicated that the overall prevalence of smokers did not change from the previous period.
Expected Results: Reduce prevalence of Canadian youth (15-17) who smoke from 15% to 9% by 2011	
Canadian Tobacco Use Monitoring Survey	10% of youth aged 15-17 were smokers. This was a decrease from the same period in 2005 when 16% of youth in this age group reported current smoking.
Expected Results: Increase number of adult Canadians who quit smoking by 1.5 million by 2011	
Canadian Tobacco Use Monitoring Survey	29% of Canadians 15+ years reported being former smokers, adding up to more than 7.8 million former smokers. Approximately 400,000 adults have quit smoking since 2005.
Expected Results: Reduce prevalence of Canadians exposed daily to second-hand smoke from 28% to 20% by 2011	
Canadian Tobacco Use Monitoring Survey	24% of Canadians reported being exposed to second-hand smoke every day or almost every day. There was a downward trend from 27% in the same period in 2005.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
63.8	62.1	55.2

The Federal Tobacco Control Strategy (FTCS) was created in 2001 to provide a comprehensive, integrated and sustained approach for the Government to reduce smoking prevalence.[64] Its goal for 2001-2011 was to reduce prevalence from 25 percent to 20 percent. To this end, Health Canada developed and administered programs, and partnered with provinces, territories and stakeholder groups to reach individuals with appropriate tools, information and resources. We

62 http://www.hc-sc.gc.ca/dhp-mps/substancontrol/analys-drugs-drogues/index-eng.php
63 http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/dscsp-psasc/index-eng.php
64 http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/index-eng.php

developed, implemented and enforced regulations pursuant to the *Tobacco Act* and added to our knowledge base through research, monitoring, and surveillance.

An evaluation of the first five years of the FTCS found that it had achieved many of its objectives. We received approval of a Treasury Board submission in 2007 on revised terms and conditions of the FTCS that resulted in identification of new targets and performance indicators for 2007-2011 that are set out in the table above.

In support of the Federal Tobacco Control Strategy, our Ontario Region worked with provincial Ministry of Health Promotion colleagues to coordinate responses involving both the federal *Tobacco Act* and the *Smoke-Free Ontario Act*. Regional consultations with Aboriginal and Francophone community stakeholders addressed tobacco prevention, cessation and education ideas and solutions. Our program officials also reached out to the tobacco retail sector to educate retailers on the *Tobacco Act*.

In response to the Supreme Court ruling upholding the *Tobacco Act* in June 2007, the Minister directed the Department to update the Act and ensure youth in particular were protected from inducements to smoke. Monitoring and analysis of emerging tobacco industry advertising continues.

At the second Conference of Parties (CoP) of the WHO Framework Convention on Tobacco Control (FCTC), Canada, along with other parties, agreed to adopt a best practices document for implementing effective protection from exposure to tobacco smoke. Canada also participated in or led working groups to prepare guidelines on product regulation, packaging and labelling, public education, cross-border advertising, and took part in the International Negotiating Body which is developing a protocol on Illicit Trade in Tobacco Products.

Our Department continued to monitor and assess contraband tobacco activities and enhanced compliance, and explored options for the next generation of tobacco control.

Strategic Outcome #3b:

Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments

Program Activity Name:
Pest Control Product Regulations

Expected Results:

- Access to safer pesticides
- Improved transparency and knowledge dissemination

Health Risk/Outcome Area: Access to safer pesticides	
Performance Indicators	**Results**
Number of new reduced-risk active ingredients available for use in Canada	15 of the 20 new pesticide active ingredients registered in 2007-2008 were reduced-risk.
Percentage of reduced-risk chemicals and percentage of biopesticide active ingredients registered/pending registration in the U.S. that are registered/pending registration in Canada	More use of joint and collaborative reviews with other countries to address common priorities. 75% reduced-risk chemicals and 37% of biopesticide active ingredients registered/pending registration in U.S. are registered/pending registration in Canada.
Health Risk/Outcome Area: Improved transparency and knowledge dissemination	
Number and type of regulatory proposals/ directives/policies published	Seven regulatory proposals, directives or discussion documents were published for consultation: • Reconsideration of Decisions under the New PCPA; • Use of Uncertainty and Safety Factors in the Human Health Risk Assessment of Pesticides; • Guidelines for the Registration of Low-Risk Biochemicals and Other Non-Conventional Pesticides; • First Aid Labelling Statements; • Compliance Policy; • Protection of Proprietary Interests in Pesticide Data in Canada; and • Registering a New Source of Technical Grade Active Ingredient under the Protection of Proprietary Interests in Pesticide Data Policy.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
50.9	62.8	58.9

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
652	582	70

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:

- Funding for Enhancing Access to Pest Management Tools
- Funding for Collective Agreements

Variances between total authorities and actual spending are mainly due to:

- Additional collection of revenue above the historical trend
- Other operating lapses in various programs

Health Canada's Pest Management Regulatory Agency (PMRA) regulates pest control products in Canada under the federal authority of the *Pest Control Products Act* (PCPA).[65] It has a mandate to prevent unacceptable risks to people and the environment from the use of pest control products. We use modern scientific techniques to assess human and environmental health risks and efficacy when evaluating and re-evaluating pest control products. As well, maximum residue limits (MRLs) are set for pesticides on food under the *Food and Drugs Act*. We encourage the development and application of sustainable pest management strategies, and facilitate access to lower risk pest control products. We address public and stakeholder concerns, and develop mechanisms to give Canadian growers access to innovative pest control products so that they can remain competitive in domestic and international markets.

New regulations under the PCPA were implemented, such as mandatory Incident and Sales Reporting Regulations, which enable us to monitor adverse impacts associated with pesticides and keep track of the quantities of pesticides sold in Canada. To date, we have received and posted close to 1,000 incident reports on the PMRA Public Registry. Incident reports help to identify any potential risks to health or the environment from use of pesticides and enable us to take corrective actions when necessary.

Under the Government's Chemicals Management Plan, our Agency worked closely with other Health Canada branches and with Environment Canada to assess high priority chemical substances and make risk management decisions to help protect Canadians and the environment from any risks these substances might pose. We were also involved in various aspects of research and monitoring efforts that will help improve pesticide exposure estimates and refine pesticide risk assessments. These activities complement ongoing surveillance and monitoring programs at Environment Canada (water monitoring), the Canadian Food Inspection Agency (CFIA) (food residues), and the United States Department of Agriculture's Pesticide Data Program (US food residues). Biomonitoring results will aid in validation of current regulatory approaches and in development of further refinements.

The Commissioner of the Environment and Sustainable Development (CESD)'s 2008 follow-up audit concluded that overall, the federal government had made satisfactory progress in managing the safety and accessibility of pesticides since 2003.[66] We were pleased with the CESD's findings that we consistently apply procedures for evaluating the risks of pesticides, and have taken action to give Canadian growers access to new and minor-use pesticides. To address concerns regarding conditional registrations, the Agency implemented measures to limit the allowable time period of conditional registrations in the future. The planning process has been adjusted to respond to CESD's concern regarding the lack of a detailed plan to meet our re-evaluation commitments.

[65] www.pmra-arla.gc.ca

[66] http://www.oag-bvg.gc.ca/internet/English/aud_ch_cesd_200803_02_e_30128.html

The first global joint review for registration of a new pesticide was completed in collaboration with the United States, United Kingdom, Ireland, Italy, Australia, New Zealand and Japan. Canada's continued participation in international regulatory cooperation activities provides Canadian growers with access to new pesticides at the same time as their global competitors.

The four main program sub-activities that support this Strategic Outcome are discussed below.

New Pest Control Products Registration and Decision-Making

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
22.5	28.0	26.1

Twenty new pesticide active ingredients were registered in 2007-2008, twice the number of actives registered in the previous year. As a result of this increased workload, we did not meet our performance target for the timely registration of new active ingredients. This issue has since been addressed by acquiring additional resources to review priority submissions.

Timely access to new, reduced-risk products in Canada is achieved via international regulatory cooperation such as joint review, work share and more effective utilization of foreign evaluations. This year, global and North American joint reviews and work shares resulted in registration of three new pesticide active ingredients. To increase the availability of pesticides in Canada compared to those available in the United States (i.e. to address the technology gap), 758 new minor uses were registered, including 459 food uses and 299 non-food uses. We are working with the U.S. Environmental Protection Agency (US EPA) and other regulatory agencies to expand the use of joint reviews and work sharing for minor uses.

The Agency continues to work on several key initiatives to increase the availability of newer, lower risk pesticides in Canada to help Canadian growers remain competitive in the global market. Four agricultural pesticides with North American Free Trade Agreement (NAFTA) labels were recently approved, which allows the cross-border movement of these products between Canada and the U.S. The Grower Requested Own Use (GROU) program allows Canadian growers, with an approved Import Certificate, to import the U.S. version of certain Canadian registered products when price differentials exist. There are 11 GROU products approved for the 2007-2008 use season. The new policy for registering generic pesticides will protect the proprietary interests of data while encouraging introduction of competing generic pesticides to the Canadian market.

Registered Pest Control Products Evaluation and Decision-Making

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
9.9	12.2	11.4

The Agency has committed to re-evaluate all 401 pesticide active ingredients registered on or before December 31, 1994. We continued to implement risk mitigation measures to address any risks that emerge during the re-evaluation of a pesticide. In 2007-2008, 30 re-evaluations were completed, bringing the number of re-evaluated pesticide active ingredients to 274, with 127 active ingredients remaining to be re-evaluated.

We continued to work with the US EPA in developing a plan for work sharing for the next round of re-evaluations. Two pilot chemicals were selected for this work sharing program and other candidates will be identified for future collaborative reviews.

Compliance

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
6.8	8.5	7.9

The Agency is responsible for promoting, verifying and enforcing compliance with the PCPA and Regulations. As described in the Compliance Policy, published in 2007, risk management principles are used to target and select situations of most concern where non-compliance is either known or suspected to exist.

We delivered 17 National Pesticide Compliance Programs. Six were compliance promotion programs in sectors such as pulp and paper mills, dry bean and sunflower production, while the other 11 inspection programs focused on production of blueberries, mushrooms, field and sweet corn, cranberries and pears. The 943 inspections completed generally found high levels of compliance. Another 342 investigations were conducted related to reported or detected non-compliance, and 363 enforcement responses were delivered to ensure or restore compliance.

At the international level, opportunities were explored under the NAFTA to coordinate activities and projects related to compliance and enforcement activities. Work was also initiated through the OECD Pesticides Working Group to create international best practices for pesticide compliance.

Pesticide Risk Reduction

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
3.1	3.8	3.6

We held consultations with stakeholders to gain national consensus on key pest management issues for lowbush blueberry and highbush blueberry, carrot and onion, raspberry, sweet corn and strawberry. Through joint work with Agriculture and Agri-Food Canada, new reduced-risk pest management practices and products are now available to agricultural growers.

Our Department is working with Canadian stakeholders to develop strategies to transition to lower risk products and management practices for pesticides being phased out through the re-evaluation process. For example, a harmonized North American approach is being developed to help the agricultural industry move from the use of azinphos methyl to lower risk pest management strategies.

STRATEGIC OUTCOME #4:

Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians

Program Activity Name:
First Nations and Inuit Health Programming and Services

Expected Results:

- Improve health outcomes by ensuring the availability of, and access to, quality health services, and supporting greater control of the health system by First Nations and Inuit

Health Risk/Outcome Area: Better health outcomes and reduction of health inequalities between First Nations and Inuit and other Canadians	
Performance Indicators	**Results**
Life expectancy (at birth, on- and off-reserve)	While still behind the Canadian average (males 77 years, females 81 years), life expectancy for First Nations has increased. In 1980, First Nations life expectancy for males was 60.9 years, for females - 68.0 years. By 2001, life expectancy for First Nations was estimated at 70.4 years for males and 75.5 for females, while life expectancy for Inuit was estimated at 64 years for males and 70 for females.
Birth weight	Statistics for 2000 indicate that 4.7% of First Nations births are classified as low birth weight compared with 5.6% in Canada overall. The high birth weight rate for First Nations is 21%, almost double the Canadian rate of approximately 13%. Health Canada is working in maternal and prenatal health to improve these outcomes.[67]
Mortality	First Nations overall mortality is 45% higher than the rest of Canada.[68]
Rates of conditions by type	Diabetes rates: • For First Nations on-reserve - 3.8 times higher than the rest of Canada. For Inuit - 47% lower than the rest of Canada.[69] Suicide rates: • For First Nations youth (10 to 19 years) - 4.3 times greater than the rest of Canada in 2000.[70] • For Inuit regions - 8.3 times higher than the rest of Canada. The rate for males is over 4 times higher than the female rate[71] (1989-2003).

67 http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/stats_profil-eng.php

68 Based on the 2000 age-standardized rates

69 First Nations Longitudinal Regional Health Survey, Statistics Canada, Aboriginal Peoples Survey, CCHS

70 Source: Health Canada, First Nations and Inuit Health Branch (Due to issues surrounding the completeness of First Nations vital statistics data, these figures may be underestimates.)

71 Statistics Canada, Mortality file

Rates of conditions by type *(continued)* Non-Insured Health Benefits (NIHB) Client utilization rates – (percentage of eligible clients who receive at least one pharmacy benefit paid through the Health Information and Claims Processing Services system in a fiscal year.)	Incidence of tuberculosis (rate per 100,000 population):[72] • Canada – 5.0 • Registered Indians – 29.0 (5.8 times higher) • Inuit – 114.3 (22.9 times higher) In 2006-2007, the national utilization rate was 64%. Regional rates ranged from 74% in Saskatchewan to 47% in the N.W.T. and Nunavut. (These are consistent with previous years' utilization rates).

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
2,130.9	2,265.4	2,227.6

Human Resources *(full-time equivalents)*

Planned	Actual	Difference
2,843	3,013	170

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:
- Funding First Nations and Inuit Health Sustainability
- Funding for the National Anti-Drug Strategy
- Funding for Collective Agreements

Variances between total authorities and actual spending are mainly due to:
- Delays in Indian Residential Schools Program
- Follow-up to Special Meeting of First Ministers reprofile
- Other operating lapses in some programs

As outlined in the RPP, Health Canada worked with First Nations and Inuit and other health partners to deliver programs and services that can be categorized under **four main priorities**, which cut across the sub-program activities for First Nations and Inuit Health listed at the end of this section.

Continued health-related programs and services

Most spending under this Strategic Outcome went to a full range of health services that Health Canada funded for delivery by others or provided directly.[73] In partnership with First Nations and Inuit, Health Canada provided primary health care services in approximately 200 remote communities, and home and community care in more than 600 communities. Health Canada directly employed 670 nurses. Including nurses funded by the Department but employed by First Nations communities, the total nursing work force is about 1,100.

Through Regional Offices and with First Nations and Inuit, Health Canada delivered community programs[74] focused on children and youth, mental health and addictions, environmental health, and communicable and chronic disease prevention and management.[75] These supplemented and supported health services that provincial, territorial and regional health authorities provided.

[72] Data from the Public Health Agency of Canada
[73] http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/index_e.html
[74] http://www.hc-sc.gc.ca/fnih-spni/services/home-domicile/index_e.html
[75] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/cdcd-dcmt_e.html

Through the Non-Insured Health Benefits (NIHB) Program,[76] Health Canada provided supplementary benefits to all eligible First Nations and Inuit regardless of their place of residence. These included coverage for drug, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation. We pursued actions to enhance client safety under NIHB such as launching point-of-sale warning and rejection messages to pharmacies concerning drugs subject to misuse; changing the formulary benefit status of certain drugs subject to misuse; and intervening with health care professionals in situations where clients were identified to be at risk in relation to their use of asthma medications.

As we pursue these continuing responsibilities, our Department faces the same challenges as other health care providers, such as increasing costs, demand for new health technologies, health human resources shortages and an aging population. Additionally, the First Nations and Inuit health system serves rapidly growing populations that demonstrate higher than average rates of disease and injuries. We face the costs of serving populations that are often dispersed across many small communities in rural and remote areas. Improving First Nations and Inuit health outcomes also requires action on the broader determinants of health, such as economic development, education, housing and culture.

Improving quality of and access to health-related programs and services

Our approach to addressing issues related to health program and service access and quality had a number of elements.

One of the most important was to attract the nursing staff needed to provide our services to First Nations and Inuit. We invested in marketing materials, recruitment tools and targeted efforts to attract new nursing graduates, Aboriginal nurses and nurse practitioners. As a result, vacancy rates improved for nursing positions on-reserve. We also developed a mentoring program to attract Aboriginal candidates entering nursing programs and a "Toolkit" to enhance nursing services. We also worked towards ensuring that nurses are prepared and supported to obtain the clinical expertise they need.

The development of *Projet ACCES* was a priority in the Quebec Region's continued efforts to improve the quality of and access to health-related programs and services for First Nations and Inuit communities. An operational framework was developed based on the notion of a single window point of access for communities to interact with our Department for these programs and services.

More generally, we worked with partners to increase the number of Aboriginal health care providers, including partnerships with professional associations, colleges and universities that fit with the Aboriginal Health Human Resources Initiative (AHHRI).[77] Through participation on the federal/provincial/territorial Advisory Committee on Health Delivery and Human Resources and

[76] http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html
[77] http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni_e.html#ahhri-irrhs

specific provincial actions, we integrated work under AHHRI with provincial and territorial health human resources planning wherever possible. The AHHRI has meant a 600 percent increase in funds to support First Nations, Inuit and Métis health career students, resulting in more than 500 Aboriginal students receiving such bursaries and scholarships.

As part of the Government of Canada's effort to ensure that Canadians receive essential health care within clinically acceptable wait times, the Department prepared to implement 10 pilot projects for diabetes and 10 for prenatal care to test wait times for First Nations on-reserve.

Our Department continued to provide services under the Children's Oral Health Initiative in over 150 communities and launched the Oral Health Information System to collect performance information that will enable us to measure program effectiveness.

To improve the working environment of clients and staff and enhance community health care, we invested $9.9 million towards the completion of 14 construction, expansion and recapitalization projects. An additional $1.5 million was invested in environmental management projects to ensure that operations met environmental codes and were consistent with the Department's commitments to sustainable development.

Our Department completed six environmental site assessments and remedial activities at 10 contaminated sites on-reserve. Of 56 contaminated sites on-reserve, 44 have been remediated, with the rest to be completed by 2012. We also inspected 94 fuel storage tanks, upgraded or replaced three tanks, and provided training in 27 communities to improve First Nations capacity to look after sites.

Through the Aboriginal Health Transition Fund and with provincial, territorial, and Aboriginal partners, we funded over 150 projects now being implemented to improve access to health services. Activities to integrate and adapt existing services included: work on governance structures, adapted and integrated protocol development across health systems, integrated information management, health system navigation tools, and training and cultural sensitivity in health services delivery. Early results are: increased collaboration between Aboriginal organizations and governments; more awareness of barriers and enablers that affect access; and greater capacity for tripartite activity.

The Department's Northern Region worked with the Government of Nunavut and Nunavut Tunngavik Incorporated to develop and implement the Nunavut Community Wellness Project. The Wellness Project, funded through the federal Aboriginal Health Transition Fund, supports development of integrated community wellness planning processes and strengthens the role of local health committees.

Integration projects pioneered through the Fund have informed British Columbia's Tripartite First Nations Health Plan, with other provinces now interested in province-wide tripartite discussions. Project initiation has taken longer than anticipated due to time needed to build relationships, and develop and implement projects.

Promoting healthy living and disease prevention

Health Canada funds or delivers a wide array of programs and services meant to promote healthy living at all ages and to address key threats to the health of First Nations and Inuit. For example, the Maternal Child Health Program for pregnant First Nations women and families with infants and young children living on-reserve continued, with 76 projects serving 176 communities. We also supported training for 60 home visitors and nurses, increasing trained Maternal Child Health workers to 110. In the North, funds enhanced health promotion programs related to the Canada Prenatal Nutrition Program and Fetal Alcohol Spectrum Disorder.[78]

The Aboriginal Head Start On-Reserve Program[79] provided over 9,000 First Nations children, ages 0-6, with a positive sense of themselves, a desire for learning and opportunities to develop fully. Since a number of federal departments have recognized the need to streamline their Early Childhood Development programming, we were engaged in demonstration projects that were implemented in 17 First Nations communities. All are testing consolidated reporting, 16 are exploring a single funding window and six are testing integration of community development approaches.

We undertook health infrastructure work to support long-term healing in Labrador Innu communities. A Healing Lodge and Wellness Centre, including an Aboriginal Head Start site, opened in June 2007, and youth safehouses in Natuashish and Sheshatshiu are operational.

The number of community-based National Aboriginal Youth Suicide Prevention Strategy projects funded and operated rose from 100 to 140. Projects focus on prevention, skills training and development of crises response protocols. We also undertook research to increase knowledge of effective prevention approaches and impacts of youth suicide. Five multi-year mental health promotion demonstration projects are now operating to test best practices. To further raise awareness, knowledge and resiliency among youth, the Department, with partners, developed a public education campaign, "Honouring Life Network"; launched a web-based information centre for Aboriginal youth and youth workers;[80] and developed a social marketing campaign including production of a toolkit for front-line workers.

A First Nations and Inuit Mental Wellness Strategic Action Plan aims to improve Aboriginal mental wellness through a coordinated continuum of mental health and addictions services that respect traditional, cultural and mainstream approaches to healing. The Plan has been validated by the Inuit Tapiriit Kanatami. Full validation by the Assembly of First Nations is expected in 2008-2009.

Our Department continued to address high rates of diabetes by providing services to more than 600 First Nations and Inuit communities. Training was offered to enhance skills of community diabetes workers and increase the number of trained community service providers. Work to establish multi-disciplinary teams was initiated and will continue into 2008-2009. These teams bring together regional leads, nutritionists, case care coordinators and physical activity

[78] http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/intro_e.html
[79] http://www.hc-sc.gc.ca/fnih-spni/famil/develop/ahsor-papa_intro_e.html
[80] www.honouringlife.ca

coordinators. Participatory research to gather more data on pre-diabetes, diabetes and its complications, and to develop strategies to reduce the burden of the disease, was also undertaken.

Complementary prevention and promotion projects were completed, such as the launch of *Canada's Food Guide*, tailored to First Nations, Inuit and Métis, and implementation of a food security interventions framework in partnership with Aboriginal organizations and other stakeholders. In addition to services offered on-reserve and in Inuit communities, the Department funded 50 Métis, off-reserve and urban Inuit diabetes prevention/promotion projects.

To identify positive impacts and lessons to be worked into future efforts, we funded an evaluation of the Aboriginal Diabetes Initiative.[81] Though focused on implementation issues, the evaluation found preliminary evidence of positive health impacts that will be examined through future studies and evaluations.

We continued to ensure access to mental health and emotional supports for eligible former students of Indian residential schools. The number of Resolution Health Support Workers increased from 53 in October 2007 to 111 by April 2008. Forty First Nations Elders were engaged to provide cultural support. Innovative approaches were implemented, such as community gatherings, community support groups and teams, healing circles, and placing workers within National Native Alcohol and Drug Abuse Program Treatment Centres. We also supported the Truth and Reconciliation Commission and the Independent Assessment Process by ensuring that appropriate health supports were available in a timely and effective manner.

All seven Regional Offices have a pandemic plan and are supporting 400 First Nations communities in planning, testing and integrating their plans with those of provincial, regional and local authorities. Funds were also invested to increase the national stockpile of personal protective equipment, which will protect on-reserve health care workers during a pandemic.

In an effort to mitigate the impacts of a possible influenza pandemic, our British Columbia Region engaged in education and planning with First Nations communities. To date, 95% of First Nations communities have participated in education workshops, in planning exercises, and in development of community-specific pandemic influenza plans.

We provided funding for the National First Nations Environmental Contaminants Program and the Northern Contaminants Program through six community-based projects on the health effects of environmental contaminants on reserves. The Environmental Contaminants Traditional Food Safety Workshop in the Yukon was conducted by the Council of Yukon First Nations with Health Canada's support, to discuss findings about traditional foods.

We have made changes to develop drinking water advisories that are more cohesive, holistic and culturally appropriate to address potential water-borne threats to health in First Nations communities south of 60°. By 2006-2007, following significant departmental investments, 89 percent of community sites had access to portable lab kits for bacteriological analysis of drinking

[81] http://www.hc-sc.gc.ca/fnih-spni/diseases-maladies/diabete/index_e.html

water. This year, 95 percent had access to a trained community-based water monitor, an increase of eight percent from a year earlier.[82]

The First Nations Indoor Air Quality Committee, composed of federal and Assembly of First Nations representatives, was developing tools for First Nations to assess the severity of mould problems on-reserve and steps to take to improve housing conditions.

Improving accountability and performance measurement

We carried out a variety of actions to improve the capacity to measure indicators of health and issues affecting it as well as initiatives such as evaluations, in addition to those mentioned previously, that enable us to assess and improve policies, programs and services.

Our Department has been working with partners to improve data quality on demographics and vital statistics, life expectancy, mortality, notifiable infectious diseases, morbidity, and non-medical determinants of health for First Nations living on-reserve. "The Statistical Profile on the Health of First Nations in Canada" is planned for publication in 2008-2009 by collating data from many federal sources, although we recognize the challenges in data coverage and quality since information is not consistent nationally.

Our Alberta Region continued to develop and implement business intelligence platforms that enhance health surveillance activities. Prototypes covering dental, vital statistics and water quality data have been developed in the past year. The Region has also begun work that is giving clinicians and epidemiologists in Alberta and Atlantic Regions access to pharmacy data and extensive analytic capacity to examine that data.

A total of $4 million was provided for the "First Nations Regional Longitudinal Health Survey (RHS)," developed and administered by First Nations. The survey is integrating traditional indigenous knowledge and a holistic health model into a scientifically rigorous survey design with preliminary results expected in 2009-2010.

Health Canada, with provinces and territories, has been developing and implementing the Pan Canadian Public Health Surveillance and Management Information System (Panorama). We intend to facilitate its implementation in all First Nations communities in conjunction with provincial implementation over the next two to five years.

The Health Integration Initiative (HII) was operated between 2003 and 2006 to explore better integration of federally funded health services within First Nations and Inuit communities and health services funded by provincial and territorial governments. It involved First Nations and Inuit communities and organizations, Regional Offices, and provincial and territorial health ministry representatives or regional health authorities in eight pilot projects as well as workshops and commissioned research scans. The national evaluation report, released during 2007-2008, found that formalized partnerships were the ones most likely to be sustained after program

[82] http://www.hc-sc.gc.ca/fnih-spni/promotion/water-eau/index_e.html

support ended. It also determined that due to differences in geographic location, size, and existing relationships among service providers, no single approach would apply to all communities.

Another evaluation assessed the First Nations Water Management Strategy. It found progress in the last five years including increased capacity for Health Canada staff and First Nations communities to sample and test drinking water quality at tap. It also generated recommendations that are being addressed through the First Nations Water and Wastewater Action Plan.

Program and Service Descriptions and Funding Details

In the RPP, the Department identified the **sub-activities under our Program Activity Architecture** that were the organizational base for our initiatives across the priorities described previously. The charts below set out details regarding our use of resources, expected results, performance indicators and results achieved for each of those sub-activities.

First Nations and Inuit Community Health Programs

First Nations and Inuit Community Health Programs support community-based initiatives in three areas: Children and Youth; Chronic Disease and Injury Prevention; and Mental Health and Addictions. With children and youth, the objective is to improve the health of mothers, infants and families, as well as support the development of children.[83] In chronic disease and unintentional injury, the objective is to deliver services that reduce chronic diseases, such as type-2 diabetes, and injuries.[84] Finally, in mental health and addictions, the objective is to deliver prevention and promotion activities on-reserve and in Inuit communities to improve physical, social, emotional and spiritual well-being.

Expected Results: Improved continuum of programs and supports in First Nations and Inuit communities	
Performance Indicators	**Results**
Number of communities with programs	• The Maternal Child Health Program for pregnant First Nations women and families with infants and young children living on-reserve supported 76 projects serving 176 communities. In Ontario, we enhanced provincial maternal and child health-related services. • Over 600 First Nations communities had access to the National Native Alcohol and Drug Abuse Program,[85] the Youth Solvent Abuse Program and mental health/wellness programs; 140 community-based suicide prevention projects were delivered. • Expanded cultural and mental wellness support for up to 80,000 former Indian residential school students was in place.

[83] http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni_e.html#immuni
[84] http://www.hc-sc.gc.ca/fnih-spni/promotion/injury-bless/index_e.html
[85] http://www.hc-sc.gc.ca/fnih-spni/substan/ads/nnadap-pnlaada_e.html

	• Over 300 First Nations communities had access to Aboriginal Head Start programs. • More than 600 communities had access to health promotion and diabetes prevention services.

Expected Results: Increased participation of Aboriginal individuals, families, and communities in programs and supports	
Performance Indicators	**Results**
Number and type of participants in programs by program type	• Approximately 9,000 children participated in Aboriginal Head Start On-Reserve programs. • All 80,000 former students of residential schools and their families could access health supports via the Indian Residential Schools Resolution Health Support Program.[86]
Number of treatment centres by type	• 54 Alcohol and Drug Abuse and seven Youth Solvent Abuse treatment centres were in operation.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
340.7	334.6	331.8

First Nations and Inuit Health Protection

Health Canada works with the provinces and First Nations communities to support a public health system on-reserve that includes basic services: communicable disease control and surveillance; prenatal education; immunization; and environmental health services (drinking water testing, health inspections etc.).

Expected Results: Improved access to communicable disease prevention and control programs for First Nations and Inuit individuals, families and communities	
Performance Indicators	**Results**
Number and percentage of communities with programs	•All First Nations communities on-reserve supported in communicable disease prevention and control programs. •Inuit communities south of 60° supported through contribution agreement funding or indirectly through National Aboriginal Organizations or transfer agreements.
Expected Results: Improved environmental health risk management	
Number of communities with access to a community-based water monitor	• 94.9% of communities had access to a trained community-based water monitor.
Number of communities with access to on-site kits for bacteriological parameters	• 89.3% of communities had access to portable lab kits for on-site bacteriological analysis of drinking water.

[86] http://www.hc-sc.gc.ca/fniah-spnia/services/indiresident/irs-pi-eng.php

Expected Results: Improved access to communicable disease prevention and control programs for First Nations and Inuit individuals, families and communities	
Performance Indicators	**Results**
Number of contaminated sites remediated	• 44 of 56 contaminated sites remediated.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
80.5	79.4	72.9

First Nations and Inuit Primary Health Care

Health Canada provides directly or funds 24/7 primary care treatment at 76 nursing stations on remote reserves, where no provincial services are readily available, and funds or provides access to home and community care such as nursing, personal care and respite in First Nations and Inuit communities.

Expected Results: Improved access to primary care programs and services for First Nations and Inuit individuals, families and communities	
Performance Indicators	**Results**
Number and percentage of communities with programs	•94% of First Nations communities have access to home care services (97% of eligible population). •100% of Inuit communities have access to home care services (100% of eligible population). •Primary care is available in about 200 remote communities.

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
264.4	271.9	309.2

Non-Insured Health Benefits (supplementary) for First Nations and Inuit

The Non-Insured Health Benefits (NIHB) Program provides approximately 800,000 eligible First Nations and Inuit with a limited range of medically necessary health-related goods and services not provided through private insurance plans, provincial/territorial health or social programs or other publicly funded programs. The benefits include prescription drugs, dental and vision care, medical supplies and equipment, short-term crisis intervention mental health services, medical transportation to access services not available on-reserve or in the community of residence, and health care premiums in Alberta and British Columbia. An Annual Report on the Program is available.[87]

[87] http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2007_rpt/index-eng.php?EditDocument

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
939.8	1,039.0	1,029.0

Governance and Infrastructure Support to First Nations and Inuit Health System

Health Governance and Infrastructure Support aims to increase First Nations and Inuit control over health programs, establish adequate First Nations and Inuit infrastructure and health services and improve capacity to generate and use health information. These activities include: health facilities; health planning and management; capacity building; consultation and liaison; integration and coordination of health services; stewardship and health research; knowledge and information management; health human resources; e-Health services; and health services accreditation.

Expected Results: Increase the number of bridging, access and student support programs for Aboriginal health career students at post-secondary institutions	
Performance Indicators	**Results**
Number of bridging, access and student support programs	32 projects funded: • 18 bridging/access and or laddering programs • 14 student support programs.
Expected Results: Facilitate the adaptation of medical, nursing and other health care curricula to increase the cultural awareness of doctors, nurses and others providing health services	
Number of health science faculties adapting their curricula to improve cultural competency of health care providers.	• 29 post-secondary education projects funded to adapt health sciences curricula, increasing cultural competency. • A framework for cultural competency developed for implementation in all 17 medical schools.
Expected Results: Increase the funding available through bursaries and scholarships to help support First Nations, Inuit and Métis students in health career studies	
Number of Aboriginal students who received Health Career bursaries and scholarships	• Through the National Aboriginal Achievement Foundation, 247 bursaries and scholarships were awarded to First Nations, Inuit and Métis health career students. • Through the Métis National Council, 376 bursaries and scholarships were awarded to Métis health career students.
Expected Results: Health facilities	
Number of health facilities	•Maintained by recipient - 948 •Maintained by Health Canada – 34
Expected Results: Access to quality health services	
Number of health facilities and services accredited	• 65 First Nations organizations were engaged in health services accreditation, with several more preparing to begin the process.

Expected Results: Improved e-Health access in First Nations and Inuit communities and regions	
Number of telehealth sites deployed by community and region	• 156 telehealth sites were active in First Nations communities with 72 more in the final stages of planning and/or deployment.
Number of communities with Internet connections	• About 90% of communities have some form of connectivity (as of 2007).
Expected Results: First Nations and Inuit community ownership, effective control and capacity to manage and administer health programs and services	
Number of contribution agreements by type[88]	• Flexible – 2 • Transfer – 158 • Transitional – 82 • Integrated – 208 • General – 1,230 • Set – 2

Financial Resources *($ millions)*

Planned Spending	Total Authorities	Actual Spending
505.5	540.5	484.7

[88] http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/index_e.html

Section III

Supplementary Information

Departmental Link to Government of Canada Outcomes

Program Activity	Actual Spending 2007-2008	Alignment to Government of Canada Outcome Area
Strategic Outcome 1: Strengthened Knowledge Base to Address Health and Health Care Priorities		
Health Policy, Planning and Information	1,357.2	Healthy Canadians
Strategic Outcome 2: Access to Safe and Effective Health Products and Food and Information for Healthy Choices		
Health Products and Food	307.9	Healthy Canadians
Strategic Outcome 3: Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments		
Healthy Environments and Consumer Safety	334.4	Healthy Canadians
Pest Control Product Regulation	58.9	Healthy Canadians
Strategic Outcome 4: Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians		
First Nations and Inuit Health Programming and Services	2,227.6	Healthy Canadians
Total	**4,286.0**	

Table 1 Comparison of Planned to Actual Spending (incl. FTEs)

This table offers a comparison of the Main Estimates, Planned Spending, Total Authorities and Actual Spending for the most recently completed fiscal year, as well as historical figures for Actual Spending.

The $8.4 million increase from Main Estimates to Planned Spending was due to anticipated funding for Indian Residential Schools Resolution Health Support Program and implementation of the Internal Audit Policy.

The $1,364.2 million increase from Planned Spending to Total Authorities is due to new program initiatives and sustainability funding which was received through Supplementary Estimates, which included compensation for individuals infected with the Hepatitis C virus through the Canadian blood supply before 1986 and after 1990, as well as funding for Canada Health Infoway and the Canadian Institute for Health Information (CIHI).

The $114.9 million decrease between Total Authorities and Actual Spending was mainly the result of:

- lapse in the Health Council special purpose allotment;
- delays in Indian Residential Schools Program;
- lapse of frozen allotment which includes:
  - Implementation of the Clean Air Regulatory Agenda reprofile
  - Drug Strategy and Community Initiatives Fund reprofile
  - Canadian Strategy for Cancer Control (Part II) reprofile
  - Follow-up to the Special Meeting of First Ministers and Aboriginal Leaders reprofile
  - Access to Medicines Regime

Table 1 Comparison of Planned to Actual Spending (incl. FTEs)

(Millions of Dollars)

Program Activities	2005–2006 Actual Spending	2006–2007 Actual Spending	2007 - 2008			
			Main Estimates	Planned Spending (1)	Total Authorities (2)	Actual Spending (2)
Health Policy, Planning and Information	375.1	290.4	263.7	263.7	1,399.2	1,357.2
Health Products and Food	256.9	262.3	257.2	257.4	316.5	307.9
Healthy Environments and Consumer Safety	277.9	294.1	333.5	333.8	357.0	334.4
Pest Control Product Regulation	54.6	62.7	50.8	50.9	62.8	58.9
First Nations and Inuit Health	1,927.5	2,088.0	2,123.1	2,130.9	2,265.4	2,227.6
Total	**2,892.0**	**2,997.5**	**3,028.3**	**3,067.7**	**4,400.9**	**4,286.0**
Less: Non-respendable revenue	(19.8)	(51.8)	0.0	(8.9)	(8.9)	(48.5)
Plus: Cost of services received without charge*	85.6	91.9	0.0	81.6	81.6	80.3
Net cost of Department	**2,957.8**	**3,037.6**	**3,028.3**	**3,109.4**	**4,473.6**	**4,317.8**
Full-time Equivalents	**8,544**	**8,686**	**8,825**	**8,825**	**9,178**	**8,899**

1) from 2007-2008 Report on Plans and Priorities
2) from 2007-2008 Public Accounts

* Services received without charge include accommodation provided by PWGSC, the employer's share of employees' insurance premiums, Workers' Compensation coverage provided by Social Development Canada, and services received from the Department of Justice.

Table 2 Voted and Statutory Items

(Millions of Dollars)

VOTE	2007 - 2008			
	Main Estimates	Planned Spending (1)	Total Authorities (2)	Actual Spending (2)
Health Canada				
1 Operating expenditures	1,691.0	1,691.8	1,880.5	1,823.3
5 Grants and contributions	1,225.8	1,233.3	1,315.3	1,258.0
(S) Minister's car allowance and salary	0.1	0.1	0.1	0.1
(S) Payments for insured health services and extended health care services	-	-	0.0	0.0
(S) Spending of proceeds from the disposal of surplus Crown assets	-	-	0.5	0.1
(S) Refunds from previous year's revenue	-	-	0.3	0.3
(S) Collection agency fees	-	-	0.0	0.0
(S) Court awards	-	-	0.0	0.0
(S) Hepatitis C virus through the Canadian blood supply before 1986 and after 1990	-	-	1,023.5	1,023.5
(S) Canada Health Infoway Inc.	-	-	38.7	38.7
(S) Implementation Act	-	-	30.0	30.0
(S) Contributions to employee benefit plans	111.4	111.5	112.0	112.0
Total Department	**3,028.3**	**3,036.7**	**4,400.9**	**4,286.0**

1) from 2007-2008 Report on Plans and Priorities
2) from 2007-2008 Public Accounts
S) indicates expenditures the Department is required to make that do not require an appropriation act.

In order to reduce the volume of printed material, Health Canada will not include all or part of the following tables in the printed *Departmental Performance Report*.

To view electronic versions of these tables, please visit:
http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/index-eng.asp.

Table 3 Sources of Respendable and Non-Respendable Revenue

Table 4a User Fees Act

Table 4b Policy on Service Standards for External Fees

Table 5 Status Report on Major Crown Projects

Name of Major Crown Project
Health Information and Claims Processing Services (HICPS)

Table 6 Details on Transfer Payment Programs (TPPs)

Health Policy, Planning and Information
Health Care Strategies and Policy Contribution Program
Contribution Program to Improve Access to Health Services for Official Language Minority Communities
Grant to Health Council of Canada
Named Grant to Canadian Agency for Drugs and Technologies in Health
Grant to Canadian Patient Safety Institute
Grant to Canadian Partnership Against Cancer
Health Products and Food
Grant to Canadian Blood Services: Blood Safety and Effectiveness and Research and Development
Healthy Environments and Consumer Safety
Payments to provinces and territories to assist in ensuring access for Canadians to effective alcohol and drug treatment and rehabilitation programs and services
Drug Strategy Community Initiatives Fund
Grant to the Canadian Centre on Substance Abuse
First Nations and Inuit Health
Nunavut Medical Travel Fund
Grant for Territorial Health Access Fund and Operational Secretariat
Payments to Indian bands, associations or groups for control and provision of health services
Contributions for First Nations and Inuit Health Governance and Infrastructure Support
Contributions for First Nations and Inuit Community Programs
Contributions for First Nations and Inuit Health Facilities and Capital Program
Contributions for First Nations and Inuit Health Benefits
Contributions for First Nations and Inuit Health Protection
Contributions for First Nations and Inuit Primary Health Care
Contributions for Bigstone Non-Insured Health Benefits Pilot Project
Contributions to the Organization for the Advancement of Aboriginal Peoples' Health
Contribution for the Indian Residential Schools Resolution Health Support Program

Table 7 Conditional Grants (Foundations)

Table 8 Horizontal Initiatives

Name of Horizontal Initiative
Chemicals Management Plan
Tobacco Control Program
Early Childhood Development
Building Public Confidence in Pesticide Regulation and Improving Access to Pest Management Products

Table 9 Sustainable Development
Table 10 Response to Parliamentary Committees and External Audits
Table 11a Internal Audits
Table 11b Evaluations

Table 12 Travel Policies

Comparison to the TBS Special Travel Authorities
Health Canada follows and uses the TBS Special Travel Authority Parameters.
Comparison to the TBS Travel Directive Rates and Allowances
Health Canada follows and uses the TBS Travel Directive Rates and Allowances.

Table 13 Financial Statements

Statement of Management Responsibility

HEALTH CANADA

Responsibility for the integrity and objectivity of the accompanying financial statements for the year ended March 31, 2008 and all information contained in these statements rests with Health Canada's management. These financial statements have been prepared by management in accordance with accounting standards issued by the Treasury Board of Canada Secretariat which are consistent with Canadian generally accepted accounting principles for the public sector.

Management is responsible for the integrity and objectivity of the information in these financial statements. Some of the information in the financial statements is based on management's best estimates and judgment and gives due consideration to materiality. To fulfil its accounting and reporting responsibilities, management maintains a set of accounts that provides a centralized record of Health Canada's financial transactions. Financial information submitted to the *Public Accounts of Canada* and included in Health Canada's *Departmental Performance Report* is consistent with these financial statements.

Management maintains a system of financial management and internal control designed to provide reasonable assurance that financial information is reliable, that assets are safeguarded and that transactions are in accordance with the *Financial Administration Act*, are executed in accordance with prescribed regulations, within Parliamentary authorities, and are properly recorded to maintain accountability of Government funds. Management also seeks to ensure the objectivity and integrity of data in its financial statements by careful selection, training and development of qualified staff, by organizational arrangements that provide appropriate divisions of responsibility, and by communication programs aimed at ensuring that regulations, policies, standards and managerial authorities are understood throughout Health Canada.

Management is supported by the Departmental Audit Committee, which ensures that the Deputy Minister has independent and objective advice, guidance and assurance as to the adequacy of risk management, control and accountability processes. Currently, the Committee is comprised of the Deputy Minister (Chair) and four members external to the Government, one of them being the vice-chair.

The financial statements of Health Canada have not been audited.

Suzanne Vinet
Acting Deputy Minister
Ottawa, Canada
Date: AOUT AUG 0 8 2008

Alfred Tsang
Chief Financial Officer
Ottawa, Canada AOUT AUG 0 8 2008
Date:

Statement of Operations (Unaudited)

HEALTH CANADA

For the year ended March 31

(in thousands of dollars)

	2008						2007
Expenses	First Nations and Inuit Health	Health Policy, Planning and Information	Health Products and Food	Healthy Environments and Consumer Safety	Pest Control Product Regulation	Total	Total
Transfer payments	1,010,464	294,311	8,740	28,361	-	**1,341,876**	1,555,641
Salaries and wages	283,713	52,061	252,171	192,180	53,844	**833,969**	895,186
Utilities, material and supplies	413,985	2,945	18,011	23,528	2,723	**461,192**	451,965
Professional and special services	314,381	11,154	44,785	62,495	9,033	**441,848**	430,972
Travel - non-insured health patient	128,922	-	-	-	-	**128,922**	122,676
Accommodation	20,324	3,894	18,132	12,534	3,719	**58,603**	52,223
Purchased repair and maintenance	17,099	2,742	11,426	13,086	2,291	**46,644**	38,070
Travel and relocation	24,715	2,547	6,620	9,629	1,078	**44,589**	37,137
Information	7,588	1,246	5,008	8,486	631	**22,959**	26,984
Communications	11,889	990	3,600	5,125	921	**22,525**	22,773
Amortization	6,325	3	6,994	6,513	242	**20,077**	21,134
Bad debts	5,895	213	704	743	141	**7,696**	623
Rentals	1,855	290	980	998	187	**4,310**	4,377
Other	1,354	54	721	398	19	**2,546**	1,021,150
	2,248,509	372,450	377,892	364,076	74,829	**3,437,756**	**4,590,911**
Revenues							
Sales of goods and services							
Services of a regulatory nature	-	-	24,299	50	4,375	**28,724**	25,754
Rights and privileges	-	-	18,918	48	3,646	**22,612**	21,308
Services of a non-regulatory nature	5,165	-	460	14,571	-	**20,196**	17,232
Lease and Use of Public Property	400	-	-	1	-	**401**	423
Revenues from fines	-	-	-	3,238	-	**3,238**	2,348
Interest	-	-	486	164	-	**650**	1,273
Other	498	150	3,606	2,423	1,245	**7,922**	8,017
	6,063	**150**	**47,769**	**20,495**	**9,266**	**83,743**	**76,355**
Net cost of operations	**2,242,446**	**372,300**	**330,123**	**343,581**	**65,563**	**3,354,013**	**4,514,556**

The accompanying notes are an integral part of the financial statements

Statement of Financial Position (Unaudited)

HEALTH CANADA

As at March 31 (in thousands of dollars)	2008	2007
Assets		
Financial assets		
Accounts receivable and advances (Note 4)	33,739	33,472
	33,739	33,472
Non-financial assets		
Prepaid expenses	-	2
Tangible capital assets (Note 5)	113,078	108,116
	113,078	108,118
	146,817	141,590
Liabilities and Equity of Canada		
Liabilities		
Accounts payable and accrued liabilities	430,715	395,377
Vacation pay and compensatory leave	39,787	39,055
Deferred revenue	3,980	3,683
Employee severance benefits (Note 6)	141,398	134,294
Other liabilities (Note 7)	478,801	1,461,712
	1,094,681	2,034,121
Equity of Canada	(947,864)	(1,892,531)
	146,817	141,590

Contingent Liabilities (Note 8)
Contractual Obligations (Note 9)

The accompanying notes are an integral part of the financial statements.

Statement of Equity (Unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	2008	2007
Equity of Canada, beginning of year	(1,892,531)	(440,699)
Net cost of operations	(3,354,013)	(4,514,556)
Current year appropriations used (Note 5)	4,286,014	2,997,550
Revenue not available for spending	(15,844)	(12,597)
Change in net position in the Consolidated Revenue Fund (Note 3)	(65,999)	(14,173)
Services provided without charge by other government departments (Note 10)	94,509	91,944
Equity of Canada, end of year	(947,864)	(1,892,531)

The accompanying notes are an integral part of the financial statements

Statement of Cash Flow (Unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	2008	2007
Operating transactions		
Net cost of operations	3,354,013	4,514,556
Non-cash items:		
Amortization of tangible capital assets (Note 5)	(20,077)	(21,134)
Gain (loss) on disposal of capital and non-capital assets	9	(31)
Services provided without charge by other government departments (Note 10)	(94,569)	(91,944)
Variations in Statement of Financial Position:		
Increase in accounts receivable, advances and prepaids	265	6,114
Decrease (increase) in liabilities	939,440	(1,456,238)
Cash used by Operating Activities	4,179,141	2,951,323
Capital investment activities		
Acquisitions of tangible capital assets (Note 5)	25,100	19,542
Proceeds on disposal of tangible capital assets	(70)	(85)
Cash used by Investment Activities	25,030	19,457
Financing Activities		
Net cash provided by Government of Canada	(4,204,171)	(2,970,780)
Cash used by Financing Activities	(4,204,171)	(2,970,780)

The accompanying notes are an integral part of the financial statements

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

1. Authority and purpose

The Department of Health was established effective July 12, 1996 under the *Department of Health Act* to participate in the promotion and preservation of the health of the people of Canada. It is named in Schedule I of the *Financial Administration Act* and reports through the Minister of Health. Priorities and reporting are aligned under the following program activities:

First Nations and Inuit Health
The First Nations and Inuit Health program activity objectives include improving health outcomes; ensuring availability of, and access to, quality health services; and supporting greater control of the health system by First Nations and Inuit. Together with First Nations and Inuit, the First Nations and Inuit Health Branch through its regional offices, delivers public health and community health programs on-reserve, these include environmental health and communicable and non-communicable disease prevention, and provision of primary health care services through nursing stations and community health centres in remote and/or isolated communities to supplement and support the services that provincial, territorial and regional health authorities provide. The First Nations and Inuit Health program activity also supports targeted health promotion programs for Aboriginal people, regardless of residency (e.g. Aboriginal Diabetes Initiative) as well as counselling, addictions and mental wellness services. The Non-Insured Health Benefits coverage of drug, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation is available to all registered Indians and recognized Inuit in Canada, regardless of residency.

Health Policy, Planning and Information
The Health Policy, Planning and Information program activity provides advice and support to the Minister, the departmental executives and to program branches in the areas of policy development, intergovernmental and international affairs, strategic planning, program delivery and review and the administration of the *Canada Health Act*. It also contributes to improved health outcomes for Canadians by promoting the increased and more effective use of information and communications technologies; by improving access to reliable health information; by providing policy research and analysis to support evidence-based decision-making; by working with official language minority communities and others to improve access to health services in the official language of choice; and by taking into account Canadians' privacy expectations with respect to health information.

Health Products and Food
Health Canada is responsible for a broad range of health protection and promotion activities that affect the everyday lives of Canadians. As the federal authority responsible for the regulation of health products and food, Health Products and Food Branch evaluates and monitors the safety, quality and effectiveness of thousands of drugs (human and veterinary), vaccines, blood and blood products, biologics and genetic therapies, medical devices and natural health products, as well as the safety of the foods Canadians eat. It also provides useful information about risks and benefits related to health products and food so that Canadians can make informed decisions about their health and well-being. Ongoing regulatory responsibilities span the life cycle of health products and food, from clinical trials to surveillance, compliance and enforcement. The branch is also facing challenges associated with rapid advances in technology and scientific breakthroughs that have resulted in the growth of an unprecedented number of biologics, genetic therapies and vaccines and genetically modified and other novel foods. These challenges are met by drawing on sound science and effective risk management in evidence-based decision-making. These disciplines are integrated into daily operations, and together with the branch health promotion activities, they enable timely access to safe and effective health products and food for Canadians.

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

1. Authority and purpose (continued)

Healthy Environments and Consumer Safety
Under this Program Activity, Health Canada addresses many elements of day-to-day living that have an impact on the health of Canadians. These include drinking water safety, air quality, radiation exposure, substance use and abuse (including alcohol), consumer product safety, tobacco and second hand smoke, workplace health, and chemicals in the workplace and in the environment. Health Canada is also engaged in other health and safety related activities, including the Government's public safety and anti-terrorism initiatives, inspection of food and potable water for the travelling public, and health contingency planning for visiting foreign dignitaries. The broad national mandate flows from legislation including *the Food and Drugs Act, the Controlled Drugs and Substances Act, the Hazardous Products Act, the Radiation Emitting Devices Act, the Canadian Environmental Protection Act, the Tobacco Act* and others. Results are delivered through partnerships and by an active presence throughout every region of the country.

Pest Control Product Regulation
To help prevent unacceptable risks to people and the environment, Health Canada regulates the importation, sale and use of pesticides under the federal authority of the *Pest Control Products Act* (*PCPA*) and Regulations. The scope of work is extensive with more than 5,000 registered pesticides - including herbicides, insecticides, fungicides, antimicrobial agents, pool chemicals, microbials, material and wood preservatives, animal and insect repellents as well as insect and rodent-controlling devices. Ongoing regulatory responsibilities constitute the majority of the work under this program activity. Using internationally accepted approaches and protocols; Health Canada conducts science-based health, environmental and value assessments. Pesticides are registered only if the health and environmental risks are considered acceptable, and if the product is effective. Health Canada sets maximum pesticide residue limits for food commodities under *the Food and Drugs Act*. Older pesticides are re-evaluated to determine if their use continues to be acceptable under current scientific approaches. Health Canada facilitates, encourages and maximizes compliance with the *PCPA* and the conditions of registration and also develops and promotes the use of sustainable pest management practices and products in cooperation with stakeholders.

The Department is responsible for the administration and enforcement of the following statutes and/or regulations, for which the Minister of Health is responsible for the Department and remains accountable to Parliament: *Canada Health Act, Canadian Centre on Substance Abuse Act, Canadian Environmental Protection Act, Controlled Drugs and Substance Act, Department of Health Act, Fitness and Amateur Sport Act, Food and Drugs Act, Hazardous Materials Information Review Act, Hazardous Products Act, Patent Act, Pest Control Products Act, Pesticide Residue Compensation Act, Quarantine Act, Queen Elizabeth II Canadian Research Fund Act, Radiation Emitting Devices Act, Tobacco Act*, and the *Human Assisted Reproduction Act*.

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

2. Significant accounting policies

The financial statements have been prepared in accordance with Treasury Board accounting policies which are consistent with Canadian generally accepted accounting principles for the public sector.

Significant accounting policies are as follows:

(a) Parliamentary appropriations
The Department of Health is financed by the Government of Canada through Parliamentary appropriations. Appropriations provided to the department do not parallel financial reporting according to generally accepted accounting principles since appropriations are primarily based on cash flow requirements. Consequently, items recognized in the statement of operations and the statement of financial position are not necessarily the same as those provided through appropriations from Parliament. Note 3 provides a high-level reconciliation between the two bases of reporting.

(b) Net Cash Provided by Government
The department operates within the Consolidated Revenue Fund (CRF). The CRF is administered by the Receiver General for Canada. All cash received by the department is deposited to the CRF and all cash disbursements made by the department are paid from the CRF. Net cash provided by Government is the difference between all cash receipts and all cash disbursements including transactions between departments of the federal government.

(c) Change in net position in the Consolidated Revenue Fund
The change in net position in the Consolidated Revenue Fund is the difference between the net cash provided by Government and appropriations used in a year, excluding the amount of non respendable revenue recorded by the department. It results from timing differences between when a transaction affects appropriations and when it is processed through the CRF.

(d) Revenues
Revenues are accounted for in the period in which the underlying transaction or event occurred that gave rise to the revenues. Types of revenues collected include medical devices, radiation dosimetry, drug submission evaluation, veterinary drugs, pest management regulation, product safety, hospital revenues resulting from payments for services provided to First Nations and Inuit Health hospitals, which are covered under provincial or territorial plans, and for the sale of drugs and health services for First Nations communities.

(e) Expenses
Expenses are recorded on the accrual basis:

- Grants are recognized in the year in which the conditions for payment are met. In the case of grants which do not form part of an existing program, the expense is recognized when the Government announces a decision to make a non-recurring transfer, provided the enabling legislation or authorization for payment receives parliamentary approval prior to the completion of the financial statements;
- Contributions are recognized in the year in which the recipient has met the eligibility criteria or fulfilled the terms of a contractual transfer agreement;
- Vacation pay and compensatory leave are expensed as the benefits accrue to employees under their respective terms of employment.
- Services provided without charge by other government departments for accommodation, the employer's contribution to the health and dental insurance plans, salary and associated expenditures of legal services and the worker's compensation coverage are recorded as operating expenses at their estimated cost.

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

2. Significant accounting policies (continued)

(f) Accounts receivable
Accounts receivables are stated at amounts expected to be ultimately realized; a provision is made for receivables where recovery is considered uncertain.

(g) Employee future benefits

i) Pension benefits: Eligible employees participate in the Public Service Pension Plan, a multiemployer plan administered by the Government of Canada. The department's contributions to the Plan are charged to expenses in the year incurred and represent the total departmental obligation to the Plan. Current legislation does not require the department to make contributions for any actuarial deficiencies of the Plan.

ii) Severance benefits: Employees are entitled to severance benefits under labour contracts or conditions of employment. These benefits are accrued as employees render the services necessary to earn them. The obligation relating to the benefits earned by employees is calculated using information derived from the results of the actuarially determined liability for employee severance benefits for the Government as a whole.

(h) Contingent liabilities
Contingent liabilities are potential liabilities which may become actual liabilities when one or more future events occur or fail to occur. To the extent that the future event is likely to occur or fail to occur, and a reasonable estimate of the loss can be made, an estimated liability is accrued and an expense recorded. If the likelihood is not determinable or an amount cannot be reasonably estimated, the contingency is disclosed in the notes to the financial statements.

(i) Environmental liabilities
Environmental liabilities reflect the estimated costs related to the management and remediation of environmentally contaminated sites. Based on management's best estimates, a liability is accrued and an expense recorded when the contamination occurs or when the department becomes aware of the contamination and is obligated, or is likely to be obligated to incur such costs. If the likelihood of the department's obligation to incur these costs is not determinable, or if an amount cannot be reasonably estimated, the costs are disclosed as contingent liabilities in the notes to the financial statements.

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

2. Significant accounting policies (continued)

(j) Tangible Capital Assets

All tangible capital assets and leasehold improvements having an initial cost of $10,000 or more are recorded at their acquisition cost. Health Canada does not capitalize intangibles, works of art and historical treasures that have cultural, aesthetic or historical value, immovable assets located on Indian Reserves and museum collections.

Amortization of capital assets is done on a straight-line basis over the estimated useful life of the capital asset as follows:

Asset class	Sub-asset class	Amortization Period
Buildings	Buildings	25 years
Leasehold improvements	Leasehold improvements	Lease term, max. 40 years
Machinery and equipment	Machinery and equipment	8-12 years
	Computer equipment	3-5 years
	Computer software	3 years
	Other equipment	10-12 years
Vehicles	Motor Vehicles	4-7 years
	Other Vehicles	10 years

(k) Prepaid expenses

Prepaid expenses include prepayments of operating expenses and transfer payments. Prepaid transfer payments consist of contributions advanced to recipients as of March 31 for which it is known that the costs will be incurred by the recipient in the subsequent fiscal year and the amount can be readily determined based on available information.

(l) Measurement uncertainty

The preparation of these financial statements in accordance with accounting policies issued by the Treasury Board of Canada which are consistent with Canadian generally accepted accounting principles for the public sector requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses reported in the financial statements. At the time of preparation of these statements, management believes the estimates and assumptions to be reasonable. The most significant items where estimates are used are contingent liabilities, environmental liabilities, the liability for employee severance benefits and the useful life of tangible capital assets. Actual results could differ from those estimated. Management's estimates are reviewed periodically and, as adjustments become necessary, they are recorded in the financial statements in the year they become known.

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

3. Parliamentary appropriations

Health Canada receives most of its funding through annual Parliamentary appropriations. Items recognized in the statement of operations and the statement of financial position in one year may be funded through Parliamentary appropriations in prior, current or future years. Accordingly, the Department has different net cost of operations for the year on a government funding basis than on an accrual accounting basis. The differences between net cost of operations and appropriations are reconciled in the following tables.

(a) Reconciliation of net cost of operations to current year appropriations used:

(in thousands of dollars)	2008	2007
Net cost of operations	3,354,013	4,514,556
Adjustments for items affecting net cost of operations but not affecting appropriations:		
Add (Less):		
Services provided without charge by other government departments	(94,509)	(91,944)
Amortization	(20,077)	(21,134)
Employee severance benefits	(7,104)	(11,961)
Refund adjustment of previous year's expenditures	34,864	40,390
Revenue not available for spending	15,844	12,597
Allowance for Bad Debt	(7,696)	(623)
Justice Canada legal fees	0	(11,785)
Vacation pay and compensatory leave	(731)	(1,918)
Other increase in liabilities (see Note 7)	986,302	(1,450,202)
	4,260,906	2,977,976
Adjustments for items not affecting net cost of operations but affecting appropriations:		
Add (Less):		
Acquisitions of tangible capital assets	25,100	19,542
Net change to accountable advances	8	32
Current year appropriations used	4,286,014	2,997,550

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

3. Parliamentary appropriations (continued)

(b) Appropriations provided and used:

(in thousands of dollars)	2008	2007
Operating expenditures - Vote 1	1 880 453	1 805 445
Grants and Contributions - Vote 5	1 315 305	1 178 285
Statutory Amounts	1 205 147	106 333
	4,400,905	3,090,063
Less:		
Appropriation available for future years	(281)	(255)
Lapsed appropriations	(114,610)	(92,278)
Current year appropriations used	4,286,014	2,997,550

(c) Reconciliation of net cash provided by Government to current year appropriations used

(in thousands of dollars)	2008	2007
Net cash provided by Government	4,204,171	2,970,780
Revenue not available for spending	15,844	12,597
	4,220,015	2,983,377
Change in net position in the Consolidated Revenue Fund		
Refund/reversal of previous year's expenses	34,864	40,390
Justice Canada legal fees	-	(11,785)
Variation in accounts receivable and advance	(267)	(6,112)
Variation in accounts payable and accrued liabilities	35,338	(7,341)
Other	(3,936)	(979)
	65,999	14,173
Current year appropriations used	4,286,014	2,997,550

4. Accounts receivable and advances

Health Canada records receivables from three main sources. As of March 31, amounts due under each of these categories are as follows:

(in thousands of dollars)	2008	2007
Receivables from External Parties	34,432	21,623
Receivables from Other Government Departments	8,021	13,992
Employee Advances	112	106
Gross receivables	42,565	35,721
Less: Allowance for doubtful accounts on external receivables	(8,826)	(2,249)
Net accounts receivable and advances	33,739	33,472

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

5. Tangible capital assets

Capital assets (in thousands of dollars)	Opening Balance	Acquisitions	Disposals/ write-downs/ adjustments	Closing Balance
Land	1,181	-	-	1,181
Buildings	127,759	937	-	128,696
Leasehold improvements	19,273	47	-	19,320
Machinery and equipment	170,538	21,112	(341)	191,309
Vehicles	21,137	3,004	(850)	23,291
	339,888	25,100	(1,191)	363,797

Accumulated amortization (in thousands of dollars)	Opening Balance	Current year amortization	Disposals/ write-downs/ adjustments	Closing Balance
Buildings	81,712	4,960	0	86,672
Leasehold improvements	17,329	1,574	0	18,903
Machinery and equipment	119,351	11,620	(341)	130,630
Vehicles	13,380	1,923	(789)	14,514
	231,772	20,077	(1,130)	250,719

Tangible capital assets net book value (in thousands of dollars)	Opening Balance	Closing Balance
Land	1,181	1,181
Buildings	46,047	42,024
Leasehold improvements	1,944	417
Machinery and equipment	51,187	60,679
Vehicles	7,757	8,777
	108,116	113,078

Amortization expense for the year ended March 31, 2008 is $20,077 (2007 - $21,134).

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

6. Employee benefits

(a) Pension benefits

The department's employees participate in the Public Service Pension Plan, which is sponsored and administered by the Government of Canada. Pension benefits accrue up to a maximum period of 35 years at a rate of 2 percent per year of pensionable service, times the average of the best five consecutive years of earnings. The benefits are integrated with Canada Québec Pension Plans benefits and they are indexed to inflation.

Both the employees and the department contribute to the cost of the Plan. The current and previous year expenses, which represent approximately 2.1 times (2.2 in 2006-07) the contributions by employees, amount to:

(in thousands of dollars)	2008	2007
Expense for the year	81,684	77,728

The department's responsibility with regard to the Plan is limited to its contributions. Actuarial surpluses or deficiencies are recognized in the financial statements of the Government of Canada, as the Plan's sponsor.

(b) Severance benefits

The department provides severance benefits to its employees based on eligibility, years of service and final salary. These severance benefits are not pre-funded. Benefits will be paid from future appropriations. Information about the severance benefits, measured as at March 31, is as follows:

(in thousands of dollars)	2008	2007
Accrued benefit obligation, beginning of year	134,294	122,332
Expense for the year	15,016	18,296
Benefits paid during the year	(7,912)	(6,334)
Accrued benefit obligation, end of year	141,398	134,294

7. Other liabilities

Other liabilities include allowances reflecting two statutory grants amounting to $471 million as announced in the Budget 2008 (*Bill C-50*: $110 million to Mental Health Commission of Canada) and Budget 2007 (*Bill C-52*: $361 million remaining to Canada Health Infoway to support the development of electronic health records). In 2007, other liabilities include allowances and contingencies reflecting $1.023 billion for Hepatitis C litigations and two statutory grants amounting to $430 million as announced in the Budget 2007: (*Bill C-52*: $400 million to Canada Health Infoway to support the development of electronic health records and $30 million to Rick Hansen Foundation for the Spinal Cord Injury Transitional Research Network).

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

8. Contingent liabilities

(a) Contaminated sites

Liabilities are accrued to record the estimated costs related to the management and remediation of contaminated sites where the department is obligated or likely to be obligated to incur such costs. Health Canada has identified sites where such action is possible and for which a liability has been recorded.

	2008	2007
Approximate number of sites for which a liability has been recorded	14	18
(in thousands of dollars)		
Liability recorded for contaminated sites	2,304	3,197

Health Canada's ongoing efforts to assess contaminated sites may result in additional environmental liabilities related to newly identified sites, or changes in the assessments or intended use of existing sites. These liabilities will be accrued in the year in which they become known.

(b) Claims and litigation

In the normal course of its operations, Health Canada becomes involved in various legal actions. There are a number of claims for which a reasonable estimate of the potential liability cannot presently be determined. Some of these potential liabilities may become actual liabilities when one or more future events occur or fail to occur. To the extent that the future event is likely to occur or fail to occur, and a reasonable estimate of the loss can be made, an estimated liability is accrued and an expense recorded on the department's financial statements.

9. Contractual obligations

The nature of Health Canada's activity results in multi-year contracts and obligations whereby the Department will be committed to make some future payments. Significant contractual obligations that can be reasonably estimated are as follows:

(in thousands of dollars)	Transfer payments	Non-Insured Health Benefits	Total
2008-09	243,000	33,000	276,000
2009-10	235,000	26,000	261,000
2010-11	203,000	19,000	222,000
2011-12	193,000	19,000	212,000
2012-13 and thereafter	97,000	61,000	158,000
Total	971,000	158,000	1,129,000

Notes to the Financial Statements (Unaudited)

HEALTH CANADA

10. Related party transactions

The department is related as a result of common ownership to all Government of Canada departments, agencies, and Crown corporations. The department enters into transactions with these entities in the normal course of business and on normal trade terms. Also, during the year, the department received services which were obtained without charge from other Government departments as presented in part (a).

(a) Services provided without charge by other government departments:
During the year the department received without charge from other departments, accommodation, legal fees, worker's compensation and the employer's contribution to the health and dental insurance plans. These services without charge have been recognized in the department's Statement of Operations as follows:

(in thousands of dollars)	2008	2007
Accommodation	41,238	34,914
Employer's contribution to the health and dental insurance plans	46,825	50,980
Worker's compensation costs	646	711
Legal services	5,800	5,339
	94,509	91,944

The Government has structured some of its administrative activities for efficiency and cost-effectiveness purposes so that one department performs these on behalf of all without charge. The costs of these services, which include payroll and cheque issuance services provided by Public Works and Government Services Canada, are not included as an expense in the department's Statement of Operations.

(b) Payables outstanding at year-end with related parties:

(in thousands of dollars)	2008	2007
Accounts payable to other government departments and agencies	24,371	18,941

11. Comparative information

Comparative figures have been reclassified to conform to the current year's presentation.

Section IV

Other Items of Interest

Health Canada's Regional Operations, An Overview

Health Canada's seven regional offices (British Columbia, Alberta, Manitoba/Saskatchewan, Ontario, Quebec, Atlantic, and Northern) represent the face of the Department to Canadians through program and service delivery, the provision of information, and as guardians and regulators.

The regions conducted outreach and engagement with partners and stakeholders including provincial and territorial government departments, regional health authorities, health boards, research and academic institutions, non-governmental organizations and First Nations and Inuit governing bodies.

Regional policy intelligence and expertise allowed the Department to respond to the diverse needs of Canadians in the areas of First Nations and Inuit health, inspection and surveillance activities, controlled drugs and substances, pesticides and health and food products.

Health Canada's regions collaborated with internal and external partners to undertake activities that support and enable more effective program delivery:

The **Atlantic Region** collaborated with the Mushuau and Sheshatshui First Nations, the Government of Newfoundland and Labrador, Indian and Northern Affairs Canada, and the Health and Healing Sub-committee of the Innu Main Table to study the immediate health effects of the move from Davis Inlet to Natuashish and to scan health conditions and concerns for inclusion in Sheshatshiu's community health plan. This led to work plans to support the two Innu communities in developing an Innu-controlled health system.

Following the adoption of a new Canadian guideline for annual average radon concentration, the **Quebec Region** is implementing an awareness program. Three workshops for the building industry were organized at which 140 professionals were called upon to either assess radon levels or take mitigating measures. A two-day seminar on the management of health and environmental risks related to the population of Quebec's exposure to radon was also offered to over 50 health professionals, providing them with the requisite skills to interact with the public.

Ontario Region supported the Great Lakes Public Health Network (GLPHN), a joint commitment under the Canada-Ontario Agreement Respecting the Great Lakes Basin Ecosystem (COA), which facilitates sharing of environmental health science among federal, provincial, and municipal governments to meet the needs of Ontario Public Health Units (PHU) and their Medical Officers of Health. The Network, managed by the Safe Environments Program, Healthy Environments and Consumer Safety, held four teleconferences to discuss the effects on human health of such environmental factors as climate change, wood smoke, pesticides and radon; two steering committee meetings; and a risk communication workshop for front-line environmental health workers. The GLPHN is a first-of-its-kind grassroots initiative to support the restoration and protection of the Great Lakes Basin Ecosystem.

The **Manitoba/Saskatchewan Region** initiated collaboration of federal departments in pandemic influenza planning. In this way, the Region advanced the Manitoba Federal Council

and Saskatchewan Federal Council's preparedness to better position the Government of Canada to manage cross-cutting issues related to pandemic and emergency management.

To address the health and environmental concerns raised by the rapid growth of the oil sands industry, the **Alberta Region** brought together regional and national expertise from all Branches of Health Canada to form the Oil Sands Working Group. The Working Group recognized the need for a more cohesive approach across the Health Portfolio and within the federal government at large.

The **British Columbia Region** helped facilitate the signing of the British Columbia Tripartite First Nations Health Plan (TFNHP) between Health Canada, the Government of British Columbia and the British Columbia First Nations Leadership Council. The TFNHP provides a framework to work together to close gaps in health between First Nations people and other British Columbians, and to ensure First Nations are fully involved in decision-making regarding the health of their people.

The **Northern Region** worked with territorial governments in Nunavut and the Northwest Territories in implementing new funding arrangements for First Nations and Inuit Health programs to reduce the administrative burden and provide maximum flexibility of resources. Through initiatives such as the Aboriginal Health Transition Fund and the Aboriginal Health Human Resources Initiative, the Northern Region provided funding to territorial First Nations and Inuit organizations to support their capacity to participate fully in these initiatives.

Advancing the Science Agenda

Health Canada depends on a strong foundation of science and research to fulfil its regulatory and policy mandates. The Department spent an estimated $349 million on science and technology (S&T), consisting of $61 million for research and development (R&D) and $288 million on related scientific activities (RSA).

Because of the scope of RSA and R&D responsibilities, the Department depends on scientists in a range of fields, including natural and life sciences and social sciences. They perform essential functions: conducting leading-edge science and policy research; providing knowledge to Canadians, health care workers and stakeholders to enable them to make sound choices to protect health and the environment; monitoring and researching health threats; and fostering sound decision-making and policy to help reduce health risks.

Health Canada worked to strengthen its science activities in three areas: advice, management and promotion.

Science advice - Promoting the effective use of science in policy-making

Independent science advice is provided through three committees.

The Science Advisory Board (SAB) provides expert, multi-disciplinary and strategic advice to Health Canada and the Public Health Agency of Canada (PHAC) regarding the science performed and used by the two organizations for evidence-based decision-making.

Health Canada's Research Ethics Board (REB) is an independent body of experts that ensures that departmental research involving humans meets the highest ethical standards. The REB met 10 times and reviewed 211 research protocols.

The Canadian Research Integrity Committee (CRIC) is working to develop a broad Canadian approach to research integrity and misconduct. Health Canada senior management has approved development of a departmental scientific integrity policy framework.

Science management - Enhancing science capacity and quality

Departmental Science Committees contribute to effective management of issues by providing regular opportunities for branches to inform and consult one another and to develop harmonized approaches to key science functions. Through coordinated consideration of the work of the Independent Panel of Experts on the Transfer of Federal Non-Regulatory Laboratories, Health Canada identified major criteria for alternative management of its laboratory infrastructure.

Health Canada worked with partners and stakeholders on a Departmental Science and Technology (S&T) Strategy to enhance the contribution of science to delivering on the Department's priorities and mandates and to strengthen the links between science and policy.

Health Canada uses its interdepartmental linkages on horizontal science and technology policy to influence and benefit from government-wide initiatives such as the 2007 S&T Strategy and the Northern Strategy identified in the 2007 Speech from the Throne. Health and related life sciences and technologies are a priority theme in the S&T Strategy. The Department has made health a focal point in discussions of the Northern Strategy and, with Health Portfolio partners (Canadian Institutes of Health Research and PHAC) has worked to ensure that scientific research, surveillance and analysis play a central role in securing improved health in the North.

Fostering linkages with external partners/stakeholders is critical to accessing science and augmenting the Department's science capacity. Major federal science and research organizations have expressed interest in more collaboration on strategic research initiatives, foresight, and access to S&T facilities.

Health Canada developed and launched a Policy on the Approval and Management of Adjunct Professorships to ensure a consistent approach to the review and approval of all academic affiliations, including adjunct professorships, of its professional employees. Health Canada also participated in the interdepartmental Scientists as Leaders Program. These science managers are receiving focused management training and are gaining broad experience to ensure the highest quality scientific support for departmental decision-making.

To strengthen research capacity, 10 additional postdoctoral fellowships were offered under the Postdoctoral Fellowship (PDF) program and the Department continued to manage the Natural Sciences and Engineering Research Council (NSERC) Visiting Fellowship Program. These Fellowship programs bring new ideas and cutting-edge science into the Department and provide Fellows with insight into the needs and operations of Health Canada, as well as identifying potential new employees.

Health Canada held workshops on intellectual property issues for scientists and managers to increase awareness of the management of inventions and patents in the Department so that the benefits from departmental research accrue to all Canadians.

Science promotion - Raising awareness and understanding of science conducted at Health Canada

The annual Health Canada Science Forum was held in Ottawa in October 2007, centering around the theme, "Integration of Science, Regulation and Policy for Healthier Canadians." Sub-themes were: 1) Emerging Science and Technologies; 2) Interactions between Health and the Environment; and, 3) Knowledge Transfer and Translation. This event helped raise awareness of the excellent science and research performed in the Department and facilitated collaboration and information sharing between Health Canada researchers and decision makers and their counterparts across Canada.

Section V

Other Information

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